Neutral Citation Number: [2024] EWHC 3511 (Fam)

Case No: NG24C50041

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/12/2024

Before :

MRS JUSTICE LIEVEN

- -

Between :

A Local Authority

Applicant

and

Mother

First Respondent

and

Father

Second Respondent

and

Lucy and Chantelle
(Children, through their Children's Guardian)

Third and Fourth Respondents

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- -

Mr James Cleary and Mr Samuel Coe (instructed by **A Local Authority**) for the **Applicant**
Ms Elizabeth McGrath KC and Mr Stephen Abberley (instructed by **Jackson Quinn**) for the **First Respondent**
Mr Brendan Roche KC and Ms Hannah Simpson (instructed by **Jones and Co**) for the **Second Respondent**
Ms Louise Sapstead and Ms Sian Waldron (instructed by **Timms**) for the **Third and Fourth Respondents**

Hearing dates: **4 -13 & 15 – 22 November 2024**

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Approved Judgment

This judgment was handed down remotely at 10.30am on 17 December 2024 by circulation to the parties or their representatives by e-mail.

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MRS JUSTICE LIEVEN

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

With the exception of Counsel, the names used in this judgment are pseudonyms.

Mrs Justice Lieven DBE :

1. This case concerns two children, Lucy, a girl aged just 16, and Chantelle, a girl aged 8. The First Respondent is the mother of both children ("M"), the Second Respondent ("F") is the father of Chantelle and has been in a relationship with the M since 2015 and has acted as Lucy's step-father since then. Lucy's father ("Mr Green") has had no contact with her since 2011 and has played no part in these proceedings. I will refer to the M and F as "the parents" for the sake of simplicity.

2. The Local Authority ("LA") were represented by James Cleary and Samuel Coe, the M was represented by Elizabeth McGrath KC and Stephen Abberley, the F was represented by Brendan Roche KC and Hannah Simpson and the Guardian was represented by Louise Sapstead and Siân Waldron.

3. Lucy has a number of very serious medical conditions which I will detail below. The allegations which lie at the heart of these proceedings, certainly so far as the M is concerned, relate to a period between May 2023 - September 2023 when Lucy was an in-patient at Manor Hospital. The LA allege that the M and/or F, whether together or separately, caused Lucy significant harm by inducing "unresponsive episodes" through the giving of Chloral Hydrate ("Chloral"). In the Threshold, as drafted at the start of the hearing, there was also an allegation of the administration of another medication, Ramipril, however in light of the expert evidence, the LA withdrew this allegation.

4. There are further allegations against the F that he acted in an "inappropriate way" to Lucy on three occasions, and that he had videos and photographs of children being sexually abused on his phone, and that he watched three videos of very young children (aged 7 and 5) being very seriously sexually abused.

5. The medical evidence and conclusions upon it are complicated by the fact that Lucy has a number of very serious underlying conditions which, on any analysis of the facts, have made her at times extremely unwell. She was given a very large number of drugs both before and during her admission at Manor Hospital, at least until the parents were stopped from any involvement in her care on 7 September 2023. This has made unpicking whether the unresponsive episodes were a consequence of any actions by the parents, or because of the high levels of medication that she was prescribed, very complex.

Factual History

6. Lucy is the sixth child of the M. The older children are all now adults. Chantelle is the only child of the M and the F together. They have been in a relationship since around 2015.

7. There had been considerable earlier LA involvement with the family. Mr Green was arrested in 2002 in relation to offences of child sexual abuse and was convicted in 2003. The older children were made subject to Child Protection Plans in 2002 because of the risk from Mr Green. Lucy was made the subject of a Child Protection Plan under the category of sexual abuse in 2009, relating to the risk posed by Mr Green, the M having remained in a relationship with Mr Green. Care proceedings commenced in 2010 and concluded in 2011 with a twelve month supervision order.

8. Lucy was born in November 2008. Lucy has had complex medical needs since an early age. The detail of her earlier years of treatment is not particularly relevant to this case, but there have been a huge number of engagements with Healthcare Professionals ("HCPs") from early in her life.

9. Dr Jones, a consultant general paediatrician at Manor Hospital, outlined the following underlying medical conditions of Lucy:

1. Unclassified neurological condition associating:

i. Symptomatic focal epilepsy (seizures involving one part of the body);

ii. Early developmental impairment;

iii. Asymmetric spastic tetraparesis (muscle weakness and increased stiffness involving all four limbs, with legs more affected than arms).

2. Possible osteopetrosis/cranio-tubular dysplasia (progressive expansion and thickening of the skull bone).

3. Chromosome 9q 33.1 microdeletion (change in Lucy's genetic make-up, clinical significance unclear).

4. Recurrent respiratory tract (chest) infections.

5. Difficulties with swallowing - currently gastrostomy-fed (tube directly into her stomach through her abdominal wall).

6. Constipation.

7. Previous episode of urinary retention requiring intermittent catheterisation – currently passing urine on her own.

8. Gastroesophageal reflux (food coming back up her food pipe).

9. Bilateral mild hearing loss most likely sensorineural (due to nerve damage) – hearing aids fitted.

10. Thoracolumbar scoliosis (curvature of the spine) – under review by Orthopaedic team.

11. Polypharmacy (on a significant number of medications).

12. Parental reporting disturbed sleep pattern – requiring multiple medications.

13. Parental reporting chronic pain/discomfort – leading to requests for multiple pain killers.

14. Visual impairment – myopic astigmatism (short-sighted).

10. These difficulties have resulted in a large number of hospital admissions for Lucy, and the involvement of medical professionals in different disciplines over many years. Dr Jones produced a report setting out a summary history of Lucy's medical issues and treatment. Dr Peter Morrell, consultant paediatrician and expert witness, has set out a very detailed medical chronology of Lucy's admissions and treatments. I will not repeat these in all their detail but have had very close regard to them.

11. There are a number of themes in the evidence and cross-examination, which are the focus of the case. These are the medications which Lucy was prescribed and the degree to which this should have been scrutinised and assessed well before 9 September 2023; whether the unresponsive episodes were caused by the interaction of the prescribed medications, rather than any overdoses given by the parents; whether Lucy was suffering from epilepsy in the period of May 2023 - September 2023, or whether her epilepsy had resolved by that time. My account of Lucy's medical history will focus on these issues, rather than other aspects of her care.

12. The principal relevance of the wider history of Lucy's conditions and care is the relationship between the parents and HCPs. There is a strong theme throughout the chronology of the parents being unhappy about the care that Lucy received, and a strong distrust of many of the HCPs. The parents assert that very serious mistakes have been made in Lucy's care, on at least one occasion nearly leading to her death. I am neither in a position to, nor would it be appropriate for me to, reach conclusions on the quality of her care in the past. However, this history is undoubtedly key to understanding the level of suspicion and animosity that the parents held to many of the HCPs.

13. Many of Lucy's issues have been present since she was a young child. She has had significant feeding problems over the years. In October 2017 a nasogastric tube was fitted and in October 2018 a percutaneous endoscopic gastrostomy ("PEG") tube was fitted so that Lucy could be fed directly into her stomach. At around the same time, an issue was raised about whether Lucy's skull was thickening which might have been related to the anti-seizure medication.

14. It is clear from the chronology that she was very ill in December 2019. She was fitted with a percutaneous endoscopic jejunostomy ("PEJ") tube which allowed her to be fed directly into her bowel bypassing her stomach. During the operation to insert the tube, her bowel was perforated and she became extremely ill. She was ultimately discharged home, but this episode appears to have led to a downturn in her overall health and development.

15. There emerges from the chronology, and then is strongly repeated through the period of the hospital admission, a theme of the M reporting that Lucy was in high levels of pain, that she was having frequent seizures and that she needed more help with sleeping, in particular through giving Chloral and Melatonin.

16. Lucy was under the care in the community of Dr Brown, consultant community paediatrician at A local hospital. There is a report in July 2020 that the M believed Lucy was still in pain and that she didn't know exactly where the pain was coming from. She also believed that Lucy was hallucinating. The M was concerned that Lucy's epilepsy had not been very well controlled and she had four seizures in the last week or so.

17. Dr Brown explained to the M that it was very difficult to suggest changes in medication because they had been started by various professionals. The M 'strongly believes Lucy needed all or a majority of them.'

18. Dr Brown suggested, if it was possible, weaning Lucy off Chloral. The M said she gave Chloral at 7pm and Melatonin at 10pm. Dr Brown suggested it may be okay for Lucy to sleep a bit less. The M said that she previously tried to wean Lucy off Chloral which didn't work, and Lucy was more distressed.

19. Lucy had respiratory problems and the M was very concerned about her blood saturation levels when she was sleeping. This too seems to have been a theme before the hospital admission that then became a fairly constant source of conflict in hospital. Lucy was seen in the Respiratory and Sleep Clinic between 2017 and January 2023. There is a report from January 2023 stating that *"objective investigations did not confirm any obstructive sleep apnoea and suggested very mild hyperventilation",* despite the M's reports.

20. A pattern emerges from this early stage of the M being very worried about Lucy and whether she was getting the right treatment; it being difficult for one professional, Dr Brown, to take an overview of such a complex case; and the M being anxious about any reduction of any medication in case it had a disastrous effect on Lucy. The M had been told that if Lucy did not sleep well then she was more likely to have seizures.

21. Lucy was admitted to Manor Hospital on 21 March 2023 for difficulties breathing and was discharged on 6 April 2023.

22. On 8 May 2023, Lucy was admitted to Manor Hospital Emergency Department with the following symptoms: not tolerating feeds through the PEJ; increased losses from the PEG; increased work of breathing and a fever. The following day she was placed in Puffin Ward where she remained until 4 September 2023. She was fairly quickly diagnosed with pancreatitis and a cause was subsequently established as being gallstones. These were removed at the end of July 2023.

23. In the period Lucy was an inpatient from May 2023 to September 2023, she was on a very extensive range of medication. These are set out by Dr Jones as being:

> *"Topiramate (anticonvulsant, for epilepsy)*
>
> *Lacosamide (anticonvulsant, for epilepsy)*
>
> *Clobazam (anticonvulsant, for epilepsy)*
>
> *Buccal midazolam (rescue medication for seizure)*
>
> *Amitriptyline (strong pain killer)*
>
> *Baclofen (for increased muscle tone)*
>
> *Chloral Hydrate (to help aid sleep)*
>
> *Melatonin (to help fall sleep)*

Cefixime (prophylactic antibiotic)

Colomycin nebulisers (antibiotic prophylaxis)

Sodium Chloride nebulisers

Glycopyrronium (to reduce oral secretions)

Omeprazole (to help treat acid reflux/heartburn)

Docusate (laxative, for constipation)

Lidocaine 5% patch (topical pain relief)

Colecalciferol (vitmain D supplement)

Biogaia Protectis (probiotic)"

The Chronology of the Admission

24. I heard very extensive evidence about a number of episodes in hospital and was shown medical and nursing notes and copious other records. I also had a very detailed chronology. I will only record here those incidents which are, in my view, material to the conclusions I reach. There was a repeating pattern of the M and the F reporting levels of pain, seizures and discomfort which were not mirrored by the nursing observations. The HCPs were increasingly concerned that the parents were exaggerating Lucy's symptoms. This discrepancy is explicable by the undoubted fact that the M was extremely anxious to the point of being seriously over-anxious, as at times was the F. I will not record these multiple occasions.

25. There are also many occasions where there are records of the parents becoming very agitated if Lucy was not given oxygen when her blood saturations dropped, even though the HCPs said this was not necessary, and the parents pressing for increased medication, particularly pain relief.

26. There were also multiple episodes when the parents reported Lucy having "seizures", but the HCPs did not observe a seizure.

27. Lucy was taken to the accident and emergency department at Manor Hospital on 8 May 2023. She was admitted and provided with a room on Puffin Ward. She remained on Puffin Ward throughout the admission, save for a brief period on HDU in early July after an operation, and all the nursing staff who gave evidence worked on Puffin Ward.

28. Lucy's immediate problem was diagnosed as pancreatitis (inflammation of the pancreas). Investigations were undertaken to establish the cause of the problem. This resulted in Lucy undergoing a cholecystectomy (removal of the gallbladder) on 3 July 2023.

29. On 15 May 2023, Dr Parkes met the parents in the morning to discuss Lucy's presentation. Dr Parkes felt at that stage that Lucy was improving and that there was a

discrepancy between what the parents were reporting and Lucy's presentation in the nursing notes. Dr Parkes recalled that the F became aggressive.

30. Later that same day, Dr Jackson (gastroenterologist) met the parents with Dr Jones. Dr Jackson had a discussion about inserting a peripherally inserted central catheter ("PICC line") for feeding intravenously through total parenteral nutrition ("TPN"). She said that this was only a very short term measure because of the significant risks involved and it might be necessary to start considering palliative care. Unsurprisingly, this was extremely distressing news for the parents and they both, in rather different ways, became very upset.

31. On 15, 16 and 21 May 2023, the parents reported Lucy having a seizure. This is another theme of the evidence. The parents frequently reported Lucy having a seizure, but this was not observed, save perhaps once or twice by the nursing staff. The parents had been told by the doctors that Lucy had epilepsy. With the benefit of hindsight, it is Dr Jones's view, and almost certainly correct, that Lucy's epilepsy had resolved by May 2023. However, there is nothing surprising, or on its own suspicious about the parents interpreting what they saw as being seizures in the light of the medical advice they had been given.

32. In the period of Lucy's admission from 1 June 2023 to 6 September 2023, when the parents were excluded from being alone with her, Lucy was reported to have the following unresponsive episodes:

    a) 1st/2nd June 2023 12.30am;

    b) 23rd June 2023 7.15pm;

    c) 12th July 2023 7.35pm;

    d) 13th July 2023 10am;

    e) 13th July 2023 3pm;

    f) 19th July 2023 5pm;

    g) 22nd July 2023 10.20am;

    h) 30th July 2023 8.45am;

    i) 9th August 2023 2.40pm;

    j) 10th August 2023 12.40am;

    k) 15th August 2023 1.45am;

    l) 4th September 2023 11.30pm;

    m) 6th September 2023 5.53pm.

33. The symptoms of the unresponsive episodes, as explained by Dr Morrell, were:

a) A period of unresponsiveness followed by fluctuating consciousness;

b) Low oxygen levels;

c) Increased heart rate.

34. The unresponsive episodes are critical to this case.

Unresponsive Episode – 1 /2 June 2023

35. Between 10pm and 12.30am on the night of 1/2 June 2023, Kylie Green, Lucy's nurse, became concerned that she was only responsive to pain and very lethargic. Lucy's oxygen saturations had fallen between 88% and 90%. Lucy's blood/gas levels were taken, involving the insertion of a needle; Lucy did not respond to this. Ms Evans put an oxygen facemask on Lucy and she appeared to improve in responsiveness by 12.30am. When a portable x-ray machine arrived for Lucy, she was sufficiently responsive, described as 'aggressive' in the nursing note, that the medical staff could not undertake the x-ray. The F had been present throughout the night with Lucy, whilst the M had not been present.

36. Earlier that day, Lucy had been very unsettled. At about 7pm, she was noted to be flushed and her face hot to the touch. She then appeared to become settled and asleep at 9pm. The parents refer to the fact that the morphine dose she had been given earlier was out of date, but the pharmacy was not concerned by that.

Messages around the use of Chloral on 2 and 8 June 2023

37. On 2 June 2023, the parents discussed the levels of Chloral that could be given (the F has confirmed that the conversation was about the levels of Chloral and not Melatonin):

"[The F] (21:12) – 'U want melotonin or Charal';

[The F] (21.22) – 'She can have 2g the internet says lol';

[The F] (21:13) – 'Give her 10 mls out the wardrobe haha';

[The M] (21:13) – 'Ohh what's 2grams';

[The F] (21:13) - Not sure it's high I think'."

38. They then agreed that 2g would be too high a dose. The F denies that he meant to use the word 'wardrobe' and suggested he was writing 'ward round'. This is disputed. The LA assert that the true reference was to Chloral which the parents had brought in from home.

39. On 8 June 2023, the M and the F joked about the M using 'the bottle of Chloral' to go to sleep whilst she was caring for Lucy that night:

"[The M] (22:04) – 'I want to go to sleep';

[The F] (22:04) – 'the bottle of choral lol';

[The F] (22:05) – '150 mls of it lol';

[The M] (22:15) – 'Lol no';

[The F] (22:16) – 'Need to get them to sort it through X'."

40. On 9 June 2023, there was a message from the M about wanting Lucy back to her normal self and the plan to go away on holiday at the end of July.

41. On 16 June 2023, the parents collected a repeat prescription of Chloral, with 28 days supply (600ml).

Unresponsive Episode – 23 June 2023

42. At around 7.15pm on 23 June 2023, Lucy had been taken for a bath by the M and the F. The emergency alarm was activated and when Ms Lowther, the allocated nurse, arrived she saw that Lucy was "unresponsive and floppy" in the bath. Lucy was returned to her room, where she remained unresponsive for around eight minutes before being given buccal midazolam and then recovering.

43. Ms Lowther said that when she went into the bathroom it looked as if Lucy was asleep in the bath but when she checked, Lucy was unresponsive. She remembered the M being concerned and "shaken up".

44. At around 5.40am on 24 June 2023, the F called the allocated nurse, Nurse Hidcote, as Lucy had pulled the nasal cannula from her nose. Lucy was described as being 'very combative' as the F was trying to reapply the cannula. The F was seen by Ms Hidcote to grip Lucy's jaw to keep her head still and shouted in her face that she needed the oxygen. Ms Hidcote formed the view that the F was losing his temper with Lucy and so asked him to move aside whilst she reapplied the cannula.

45. The next day in the afternoon Nurse Sackville, a nurse, attended Lucy to cut down the PEJ tube due to a leak. The F was noted to become angry and aggressive, in the presence of Lucy, saying 'well if that's all that's needed we could have done that yesterday' and 'we were told to leave it alone and not touch it so do what you want…'. Ms Sackville said that she could leave it and wait for a surgeon, but the M indicated she was content for Ms Sackville to proceed.

46. There is reference in the notes to Lucy having an unresponsive episode at 7pm on 25 June 2023, but it is not relied upon by the LA given the lack of detail. She appeared to respond to a dose of buccal midazolam.

47. Over the next few days, there are a series of texts relied upon by the parents which show them worrying about Lucy's care, being angry with the nurses and the M being very keen for Lucy to be discharged from hospital. They also show the M being absolutely clear that she knew what was best for Lucy and believed the hospital staff to be basically incompetent.

48. On 3 July 2023, Lucy had gallbladder removal surgery, intended to cure her pancreatitis.

49. Throughout this period, there had been tension between the parents and the HCPs about how Lucy should be fed and given her medications, whether through the PEG or the PEJ. The nature of the dispute is not relevant, but it was a fairly constant source of problems. On 13 July 2023, Nurse Harlow, the nurse on duty at the time, put up a chart (or note) setting out which route each medication should be placed through.

Unresponsive Episode – 12 July 2023

50. On 12 July 2023, at 7.35pm, Nurse Wisley, the allocated nurse, was called by the parents because Lucy's arm was twitching slightly and she became unresponsive. Nurse Wisley waited for about five minutes before administering a dose of buccal midazolam, as per the guidance the nurses were given, but Lucy remained unresponsive. A further dose of buccal midazolam was given but again Lucy was unresponsive. Lucy's oxygen levels were at 89% but with oxygen given by a mask it increased to 95%. Lucy's heart rate was at 100 beats per minute. The treating medics considered referring Lucy to the high dependency unit, but she remained on the Ward under observation. By 7am, on 13 July 2023, Lucy had recovered and was noted to be playing on her iPad.

51. This episode is notable because it went on for a very long time and Lucy did not respond to buccal midazolam, which strongly suggests the unresponsive episode was not a form of epileptic seizure.

52. Nurse Wisley in oral evidence said that she could not remember the incident and was entirely reliant on her notes.

53. There are text messages between the parents the next day where they discuss Lucy being sleepy which the M is worried about; the F says *"we need to know why she had it…."*.

54. On 13 July 2023, there was a Multi-Disciplinary Team ("MDT") meeting which was postponed. It was decided on that date that all medications would be given by staff from then on. From this date onwards, it appears that the M and F stopped giving Lucy the medications.

Unresponsive Episode – 13 July 2023

55. At 10am, on 13 July 2023, the parents pulled the emergency buzzer reporting that Lucy had been awake and then suddenly became unresponsive. After eleven minutes, buccal midazolam was administered and Lucy was able to respond to pain thereafter. Lucy's oxygen saturations were at 96%, though with oxygen being administered, and her heart rate was at 90 beats per minute to 100 beats per minute. The Glasgow Coma Scale ("GCS") score was between 3 and 7 (a measure of conscious level, scored from 3 - 15 and with 3 as totally unresponsive). Lucy had recovered by 1.15pm. Both parents were present during the episode. Nurse Harlow, the allocated nurse, said in her statement that "…to my knowledge there were staff present when the seizure started". However, it was unclear from the nursing and/or medical records whether other staff were present, and if so, who. Nurse Harlow in oral evidence could not recall why she had said staff were present but said that must have been her recollection when she wrote the statement.

56. At around 3pm, Lucy became unresponsive again. Lucy's oxygen saturations were around 80%, though improved with the administration of 15L of oxygen and her heart rate was around 90 beats per minute to 100 beats per minute. A further dose of buccal midazolam was administered at 3.10pm (or 3.19pm, there is a discrepancy between Nurse Harlow's statement and the nursing record). Lucy remained unresponsive until 6pm when her GCS score was 14. It is unclear from the evidence if the parents were present at the start of this episode.

Unresponsive Episode – 19 July 2023

57. The M had been with Lucy during the day on 19 July 2023 and the F had returned at around 5pm. Thereafter, Nurse Harlow, the allocated nurse, was called into the room because Lucy had become unresponsive. Nurse Harlow noted that Lucy's oxygen saturations were at 90% and she was not responding to pain. Lucy was given oxygen and remained stable. It was not noted when Lucy recovered, though by 10.25am the next morning she was described as 'alert' by a treating doctor.

58. It seemed from Nurse Harlow's evidence that it was not clear when she entered the room whether Lucy was falling asleep or was unresponsive, but she was clear that Lucy did then become unresponsive.

Unresponsive Episode – 22 July 2023

59. At 9.45am, the F activated the emergency alarm because Lucy was unresponsive. Nurse Bridgewater, the allocated nurse, attended and the F told her that Lucy had a 'seizure' which had lasted for a few seconds. Lucy's oxygen saturations were at 91% and she was put on 15L of oxygen, and her heart rate was at 128 beats per minute. The GCS was 3. Lucy remained unresponsive for the next '3 - 4 hours'. No 'rescue medication' was given.

60. Ms Bridgewater said that Lucy had been unresponsive for 3 - 4 hours but had maintained her airway open. She was kept under frequent observations during the period.

61. Between 25 July 2023 and 27 July 2023, Lucy was placed on constant supervision by nurses (1:1 nursing). This was to allow 'observation and documentation' of episodes. There were no unresponsive episodes or anything described as a seizure during this time.

62. On 29 July 2023, Nurse Bridgewater was on duty when the F pressed the call buzzer. She went into the room and saw the F on the bed in what she described in her notes as "the spooning position". She felt this was sufficiently noteworthy to put into the nursing notes and her statement. It was very difficult to know what to make of this episode. Nurse Bridgewater said she had a sense it was noteworthy, but it was not possible to pin down what gave her this sense.

Unresponsive Episode - 30 July 2023

63. On 30 July 2023, at around 8.45am, the F activated the emergency alarm. Lucy was reported as having been playing on her iPad and then suddenly became unresponsive and remained so until around 5pm. Nurse Hidcote, Lucy's allocated nurse, noted, at

10.40am, that she was not responding to 'touch, voice or pain'. Lucy was given oxygen by nasal cannulas and maintained saturations of around 92% and had a GCS score of 3. Buccal midazolam was not given. Lucy's heart rate was initially 190 beats per minute. The GCS score remained at 3 until around 5pm when Lucy became responsive. The F was observed by Ms Hyde, a nurse, during the morning to be 'frustrated and angry' saying that 'they' think this is normal (in apparent reference to the doctors).

64. The F was present at the start of the episode and the M entered the Ward later.

65. It was noted in the medical records on 1 August 2023 that *"the parents are completely against changing any dose of medications other than Keppra"*.

Messages around the use of Chloral 9 August 2023

66. The M and F had further discussions about the need to increase the dosage of Chloral on 9 August 2023:

> *"[The M] (06:48) – 'U need to also tell neuro about the seizure and ask if we can go up on chloral as I think she needs a bigger dose with a back up still if needed now she's older xx';*
>
> *...*
>
> *[The F] (06:49) – 'Yeah to keep her settled.'"*

67. The F has accepted with this message that he and the M were concerned because the neurology doctors had said that if Lucy did not sleep, then she would be at an increased risk of seizures. This is one of a series of messages about Lucy's sleeping and whether she should be given oxygen.

Unresponsive Episode – 9 August 2023

68. On the morning of 9 August 2023, there was an MDT meeting to consider the discharge home of Lucy and the concerns that Lucy had seemed to be well when monitored on 1:1, but then became ill again when that stopped. Possible discharge on 14 or 15 August 2023 was discussed. One of the neurologists raised that some of Lucy's seizures were "not convincingly epileptic". Ms Dixter raised her concerns with the medical team about the timing of the unresponsive episodes. It seems reasonably clear by this stage, if not earlier, that the nursing staff were becoming increasingly concerned that the parents had some role in inducing some of Lucy's symptoms.

69. The F told Ms Hyde, the allocated nurse, that he was going to take Lucy to the The Lamps shopping centre. As the F left the Ward, with Lucy in a wheelchair, he asked Ms Hyde, 'what do I do if she has a seizure and becomes unresponsive?' Ms Hyde responded, 'call an ambulance or bring her back if you're close by'. I note that when Lucy was taken out of the hospital, milk and buccal midazolam would be taken and could be fed through the PEJ. It was therefore possible for drugs to be administered even when she was out of hospital.

70. At 2.48pm, the F called the Ward and spoke with Nurse Eden. The F said that Lucy was becoming unresponsive. Nurse Eden advised the F to call an ambulance.

Although there was implied criticism of the F for not calling an ambulance, he was very close to the hospital, albeit he had to push Lucy up a hill. The F had texted the M at 2.15pm saying that Lucy was not right.

71. At approximately 3pm, the F arrived at the Ward with Lucy (having not called an ambulance). Ms Eden let the F and Lucy go into the Ward. Lucy was transferred to her bed. Ms Eden noticed that Lucy's lips were becoming blue and applied 15L of oxygen by mask. Lucy was unresponsive and not responding to pain. The GCS was 3. The cardiac arrest ('crash') team were called. Lucy's heart rate was 160 beats per minute and her oxygen saturation was at 96%. The F provided the nurses with a dose of buccal midazolam from his bag and this was administered to Lucy at around 3.07pm. The F was talking during this time about how he had 'run up the hill' with Lucy.

72. Lucy stabilised, though remained unresponsive. At around 4.30pm, the F activated the emergency alarm. Ms Dixter, the ward manager, returned to find Lucy making a 'grunting' sound. Ms Dixter asked the F to move out of the way so she could commence a 'jaw thrust' on Lucy to open her airway. The F laughed, saying 'oh Jenny, I forgot you're a proper nurse'.

73. Lucy remained unresponsive until around 5.50pm.

74. On 10 August 2023, at around 12.40am, Ms Evans, the allocated nurse, noticed that Lucy had become unresponsive and was not responding to pain. No action was taken as Lucy was judged to have 'a stable airway', though the high dependency unit were made aware of the situation. 1:1 nursing then started from 12.50am due to the need to monitor Lucy, though due to the demands on the Ward there would have been some breaks in this. Lucy became more responsive at around 1.20am, improving during the night until she was fully awake by 6.20am (it being noted she was 'batting away her nebuliser'). The F was present throughout the night and the M was not present.

75. The F did not tell the M about the episode when she messaged him later that morning:

> *"[The M] (7.04am) – 'how is she';*
>
> *[The F] (7.05am) – 'She woke up at 4 then back. To sleep she's ok though no rush x'"*

76. The F said in oral evidence that the staff would have told the M, which is why he did not do so.

77. At around 10am on 10 August 2023, Nurse Hascombe, the allocated nurse, was preparing a feed for Lucy. When Ms Hascombe went into the room, the F was holding a syringe. The F explained that he was administering a flush to Lucy prior to the feed, there was water next to the syringes. The 1:1 observation which had commenced at 00.40 had stopped by 5.40pm.

78. A prescription for Chloral was provided by Lucy's GP, at the request of the M, on 10 August 2023.

79. The M and the F messaged about increasing the dosage of Chloral on 12 and 14 August 2023:

> *"[The M] (12th August 2023) (07:23) - 'Maybe upping chloral might work';*
>
> *[The F] (07:24) – 'Not sure we can ask xx'*
>
> *[The M] (14th August 2023) (07:20) – 'Think chloral needs upping as from 1am she couldn't cope x.'"*

80. The F has said in respect of these messages that he and the M remained concerned that Lucy was not sleeping. The F said the 14 August 2023 message related to the additional 5ml dose of Chloral not being allowed after midnight. This is disputed as the reference is to 'upping' and not a variation of the times for administration of it.

The F's aggression towards LUCY and the Medical Staff

81. Nurse Helligan, the allocated nurse, observed on 12 August 2023 the M and the F putting Lucy in a wheelchair to be taken on a walk around the Ward. It was noted that Lucy's oxygen saturations were at 92%. The F '…grabbed [Lucy's] head aggressively/forcefully and held her head up straight'. Lucy was then taken for a walk around the Ward.

82. On the same day, Ms Heligan collected two samples of Lucy's urine, one to be sent to toxicology to check what substances were in her urine and the other to check for infections. The samples were taken when the M had placed the catheter into Lucy but Ms Heligan collected the samples. This is the sample which was subsequently found to have Ramipril in it, which is prescribed to the M for high blood pressure. Dr Berry accepted that it was possible that the M had Ramipril on her skin and this got into the sample if the M had not washed her hands nor wore gloves. The M said she had not washed her hands or sanitised them when she catheterised Lucy.

83. The next day at around 4pm, Ms Heligan noted that the F was 'very aggressive and shouting' about the care that Lucy was receiving following her retching. The F noted 'no one had cared about [Lucy] all weekend' and 'she is going downhill, and no one is doing anything about it'. Lucy was present.

Unresponsive Episode – 15 August 2023

84. Ms Evans was again Lucy's allocated nurse on the night of 14/15 August 2023. Lucy was 'bright and alert' as Ms Evans started her shift. Ms Evans noted that the M had changed into her pyjamas with the intention of staying overnight with Lucy. Ms Evans described how the F '…insisted that he would stay on the Ward with [Lucy]'. The M therefore went to the parent's accommodation ("Bluebell House").

85. In her oral evidence, Ms Evans agreed that the M struggled to sleep when she stayed overnight with Lucy and therefore became very tired. The F found it much easier to sleep on the Ward.

86. At around midnight, Ms Evans noted that Lucy became unresponsive, her oxygen saturations decreased and her heart rate went to 170 beats per minute. As the episode continued, Lucy's heart rate continued to increase. The crash team were alerted and arrived at 12.50am. Lucy's heart rate was at 200 beats per minute and her pupils had been dilated for around five minutes. Buccal midazolam was administered at

12.54am. Lucy was placed on 15L of oxygen. A further dose of buccal midazolam was administered at 1.40am. Lucy's heart rate returned to less concerning levels, though she remained unresponsive. At 2.50am, further concerns were noted about Lucy's increased work of breathing and that her heart rate was at 164 beats per minute. Ms Evans noted that the F '…did not seem too concerned about [Lucy's] condition and was engaging in normal conversation with myself about my holiday and laughing'. The F had called the M and she returned to the Ward. Lucy remained unresponsive throughout the day, though was observed to be 'awake slightly' and moving her legs at 5.50pm.

87. 1:1 observations were put in place following this episode from 15 August 2023 to 24 August 2023. There were no unresponsive episodes during this time.

88. On 20 August 2023, it is agreed that the M brought in Chloral from the supply she had at home at the request of the nurses. This is recorded by the pharmacist in the drug charts. I will set out below at paragraphs 162 - 166 the evidence about the quantum of Chloral at home and what appears to have happened to it.

89. Between the 23 August and 28 August 2023, the M was at home with Covid.

Messages around the use of Chloral on 23 and 24 August 2023

90. On the morning of 23 August 2023, the M again raised the need to 'up' the dose of Chloral:

> *"[The F] (08:48) – 'She was up at 5 lol';*
>
> *[The M] (08:49) – 'I know she rang me lol need to ask neuro to look at upping her chloral.'"*

91. In the evening, there was a further discussion about whether Lucy could have a higher dose of Chloral whilst in hospital:

> *"[The M] (19:28) – 'How much chloral did [Lucy] have';*
>
> *[The F] (19:29) – '15ml';*
>
> *[The M] (19:29) – 'Ohh normal';*
>
> *[The F] (19:29) – 'Then just 5 extra if she needs it';*
>
> *[The M] (19:30) – 'As before lol thought they sed she could have more in hospital';*
>
> *[The F] (19:30) – 'Other Niro said no lol';*
>
> *[The M] (19:35) – 'Ahh ok.'"*

92. It is unclear if 'niro' is a typographical error, and actually means 'neuro'. The following day the M asked the F to ask 'niro' again about the Chloral dose:

> *"[The F] (12:31) – 'The horrible Niro women is outside let the war begin lol';*
>
> *[The M] (12:32) – 'Ffs she's a fukin nightmare ask her about chloral tho lol she might say different lol xx"*

Multi-Disciplinary Team Meetings on 24 August 2023 and 30 August 2023

93. There was an MDT meeting on 24 August 2023. There was a discussion around the unresponsive episodes and Dr King (consultant neurologist) gave the opinion that these were not seizures. Dr King also noted that, *"when professionals try to omit Chloral or Clobazam M and [F] are very resistant"*. It was noted that the nursing staff had concerns, though these were not specified in the minutes, but the agreement of the meeting was to withdraw the 1:1 observation of Lucy.

94. On 27 August 2023, at 7pm, Ms Kew went into the cubicle and found that Lucy was vomiting whilst lying flat and the F was on the phone to the M. Lucy was always in bed at 45 degrees because she had an unsafe swallow and frequently vomited. Lying flat was therefore obviously unsafe. The F said that he was changing the sheets and that was why she was lying flat.

95. There are a series of texts on 28 August 2023 whilst the M is at home with Covid, where she is obviously concerned about Lucy. However, she is adamant that Lucy should not come home from the hospital *"till Gastro sort her properly"*. All the texts show the M as being totally certain that she, and only she, understands Lucy's needs and her being in constant "fight mode" with the HCPs.

96. On 29 August 2023, Ms Hampton (a play therapist), went into Lucy's cubicle and found the F in bed with Lucy. She found this odd because Lucy was visibly uncomfortable and said three or four times to him to "get out". This was another incident where it was very difficult to reach any clear conclusion. The parents did on occasion get into bed with Lucy to help settle her. Lucy was sometimes vocal and angry and so her telling the F to get out of bed and him not responding was not necessarily suspicious.

97. On 30 August 2023, there was a further MDT meeting to discuss discharge planning. There had been a meeting with the M and F earlier that day to discuss discharging Lucy home. Concerns were raised at the meeting that when discharge was raised something always seemed to go wrong with Lucy. Ms Dixter raised her concerns about the F's behaviour with Lucy:

> *"During 1:1 [Lucy] remained well, no oxygen requirement, no seizures, retching that is normal for [Lucy], no vomits. [The M] went home over the weekend due to [Lucy's] sibling being unwell and [the M] being unwell with a stomach bug.*
>
> *Once 1:1 removed [F] reported increased retching, vomiting and loose stools. That [Lucy] wasn't tolerating her feeds. They also reported milky*

> *aspirate in her gastrostomy bag whilst on free drainage, hallucinations/seizure and that they were unhappy to take her home on the planned date of 29/8…*
>
> *[F] reported to Jenny and ward staff that Dr Hallet had said all [Lucy's] medications are to go via her JEJ. Neurology have clearly stated that her epileptic medications are to go gastric, nursing staff made it clear to [F] that they wouldn't be changing anything until Dr Hallet had documented this or given them instruction to do so, however [F] kept pushing the matter."*

98. On 1 September 2023, there was a further meeting to discuss discharge. Ms Dixter raised a concern that the parents seemed to be reluctant to allow Lucy to go home and about the F's behaviour.

99. At around 2pm on 3 September 2023, Nurse Gatton found a 20ml syringe on the patient's drawer in Lucy's room. The syringe had been pulled back 5ml and there was some liquid therein. Ms Gatton and Ms Sackville smelt the liquid and thought it did not smell like any of Lucy's medications. A cap was placed on the syringe and it was put back into the patient's drawer.

100. Ms Sackville gave evidence about this incident. It was odd that having suspected that the parents had been putting something untoward into the syringe, presumably to then give to Lucy, Ms Sackville did not then immediately raise this with more senior staff. She simply said that the Ward was very busy that day and she didn't think of it.

101. The next day Ms Dixter attempted to locate the syringe and one matching the description was found in a bin (the room having been cleared ahead of Lucy's discharge). Ms Dixter took a photograph which she sent to Ms Gatton who confirmed it was the same syringe. The syringe was no longer pulled back to 5ml, though Ms Dixter was still able to see a very small amount of liquid in it. The syringe was subsequently given to the police, though no testing was undertaken of the contents (as such, no allegations are pursed by the LA about the contents of the syringe).

102. On 3 and 4 September 2023, the F was viewing child sexual abuse material and communicating with another person about the contents of the images.

103. Lucy was discharged at 1.30pm on 4 September 2023. She was taken home by the M and her sister, Janine. The F said he got home from work at about 4.15pm. He and the M then decided to take some things from the house to the local waste tip.

104. At 7.40pm, Nurse Lacey, a nurse, answered a call from the F to the Ward (from which Lucy had been discharged). The F said that Lucy was having an unresponsive episode at home. Ms Lacey advised the F to take Lucy to the nearest hospital accident and emergency department. Lucy was taken to Manor Hospital by ambulance. Upon arriving at the hospital, the M and F explained that Lucy had a temperature of 38.1 degrees Celsius. The M and F reported that Lucy had become unresponsive at home; this had resolved, though she had then become unresponsive again and the M had given buccal midazolam at 7.45pm.

105. Lucy returned to the Ward at 11.30pm. Lucy remained unresponsive, was on 2L of oxygen and had a high heart rate. Lucy had recovered by 3pm on 5 September 2023, though remained lethargic.

106. There was an issue with the Bluebell House keys. The F told the nurses that the M had taken them home by accident. However, the M now says that she actually took them to give to another family but told the staff she had kept them by accident so as not to get the other family (Jackie) into trouble. Jackie told Ms Dixter that the M had given her the key "in case they came back in". As explained below, I do not think the M was being truthful in this regard.

107. There are a number of text messages on the night of the admission that show the M being extremely "fed up" with the situation and with the F, who she felt was not supporting her and Lucy.

108. The F had a conversation with Ms Hidcote where he insisted that the unresponsive episodes were "seizures" and should be treated as such.

109. An MDT discussion took place on 5 September 2023 in which concerns were noted around Lucy's 'perplexing presentation' and re-admission after only six hours. The next day, Dr Parkes was concerned that the M was exaggerating Lucy's symptoms and was not accepting the objective evidence of Lucy's condition.

110. Lucy had been with the M on the Ward all day on 6 September 2023. Ms Evans, the allocated nurse, saw the F enter the Ward and go to Lucy's room at 5.30pm. At 5.53pm, the emergency alarm was activated. Ms Evans went to Lucy to find her oxygen saturations at 89%, unresponsive to pain and with dilated pupils. The GCS score was 3. Lucy was placed on 15L of oxygen.

111. Ms Heligan, a second nurse who attended, noted that the M was very upset, visibly concerned and stood with Lucy throughout. The F in contrast was '…sitting on the parent bed watching Tik Tok, cutting out stickers for work and he was laughing/joking saying 'it's just [Lucy] doing her usual silly thing'. Ms Heligan was of the view that the F did not appear to be concerned. Ms Evans made similar observations and noted that the F had asked 'Becky, do you have a new uniform?' The F also said that prior to the unresponsive episode that Ms Evans had been in the room and that Lucy had been awake, laughing and singing. This did not accord with Ms Evans' recollection that she remembered walking past the room and waving to Lucy, who had waved back.

112. Although both parents had been present, a different nurse heard the M say she had been in the parents' room when Lucy had become unresponsive. The M confirmed this to the police.

113. On 7 September 2023, Dr King, together with Dr Parkes, met the M to discuss Lucy's presentation. This was the first time that Dr King had met Lucy since her admission in May 2023, although he had met her in the past. He was concerned that the seizures were not epileptic and explained this to the M. Dr King thought that overmedication might be causing some of Lucy's issues and suggested reducing the medication. It is agreed that the M was very worried that Lucy might become much sicker, and even

die, if the medication was withdrawn. The M appears to have been very resistant to the idea that the seizures were not epileptic or that the medication should be reduced.

Police Involvement

114. In the afternoon of 7 September 2023, the toxicology tests results of a urine sample taken from Lucy on 12 August 2023 were received on the Ward. This indicated the presence of Ramipril and Primidone in the sample. Ms Heligan was Lucy's allocated nurse that afternoon. Ms Heligan knew that Lucy was not prescribed these drugs and confirmed this. Dr Parkes, the duty consultant paediatrician, was contacted and the police were called. It was decided to reintroduce 1:1 supervision of Lucy. When Ms Sackville gave Lucy medication at 6pm, the F queried why he and the M could not do this. Ms Sackville said it was to ensure continuity of care, which was not the true reason. The F then became 'very aggressive and hostile', shouting at Ms Sackville and the M 'why don't they trust us?' The M left the room very upset. Ms Sackville followed and spoke to the M, who said 'I don't know why he's angry [F], because he knows that you lot [nursing staff] don't think we are doing anything'.

115. The M and the F were arrested at around 7.30pm on suspicion of administering a poison with intent to endanger life or commit grievous bodily harm. Lucy's room was secured by the police from 8.30pm with a record kept of those entering and leaving. The Bluebell House rooms were similarly secured from 9.19pm with a record of those entering and leaving.

116. Lucy remained in hospital and Chantelle was placed with her paternal great grandfather under a voluntary arrangement.

117. On 7 September 2023, Dr King and Dr Parkes reviewed Lucy's medication. Dr King was concerned that many of Lucy's symptoms could be attributable to overdose of drugs interacting on the Central Nervous System ("CNS"). A decision was made to reduce CNS acting medications. The reduction of the prescribed medication is critical to the parents' case and I therefore set out below precisely what was reduced and when.

118. Dr Jones produced a table of drug changes which each of the experts considered. I will not produce this in full, but I have had close regard to it. On 9 September Chloral was stopped, but then reintroduced on 14th September at a lower dose because Lucy was showing withdrawal symptoms. Baclofen was reduced on 9th September. On 14th September Clobazam and Amitriptyline were reduced. On 16th October there were further reductions of drugs acting on the CNS. However, I note that the dramatic improvement in Lucy's presentation had already well commenced by then.

Police Search

119. At 1.15pm, on 8 September 2023, a police officer undertook a search of Lucy's room. The officer found a rucksack and within this was an empty box of Chloral and a 'half full' bottle of Chloral. The bottle was a 150ml bottle and was issued on 14 August 2023 and had an expiry date of 9 November 2023. Several syringes, and the empty packet of a syringe, were found in a plastic tub. A syringe with small amount of orange fluid in it was also found (the fluid was not tested by the police). This was a

different syringe to the one found by Ms Gatton on 3 September 2023 (which was also seized by the police).

120. On 9 September 2023, the police searched the home of the M (the parents did not publicly say they lived together because of the welfare benefit consequences, but the F accepted in oral evidence that he did spend most nights at the M's home). Two bottles of Chloral were found on the top shelf of a storage cupboard in the hall. Two further bottles of Chloral were on the middle shelf. From the police photographs, one bottle was issued on 20 June 2023 and the others on 14 August 2023, all 150ml bottles. The expiry of the 20 June 2023 bottle was 17 September 2023 and the 14 August 2023 ones expired by 9 November 2023. A bottle of Chloral was found on a shelf in Lucy's bedroom. This was issued on 22 March 2023. The expiry date was not shown. A bottle of Chloral was also located in the bathroom, though this was not photographed by the police.

121. A search was undertaken of the F's car, and the empty packaging for a syringe was found.

122. Lucy's progress since 8 September 2023 has been extremely striking. She has had no unresponsive episodes since then. Dr Jones noted (as at 10 May 2024):

> *"7.1 From 8th September [Lucy] was noted to make considerable progress with regards her medical treatment, social interactions, and access to education.*
>
> *This change has been observed by multiple health and allied professionals who have been involved with Lucy during her recent admission or prior to that in the community."*

123. Dr Jones noted that Lucy had developed more strength in her limbs and could move herself from side to side and her communication had become significantly better than it was at the time of her hospital admission.

124. Dr Parkes reported that since 8 September 2023 and whilst still in hospital:

> *"In the days and weeks after her parents were removed, she was alert, asserting opinions, chatting, being grumpy and generally behaving like a teenager. She no longer needed catheterising, was sleeping without medication and demonstrating a significant change in her muscle power and ability to move. We saw no further episodes of unconsciousness unexplained tachycardia or flushing and she was weaned off many of her medications and tolerated her feeds. Colleagues universally commented positively on her improvement."*

125. Lucy was discharged from Manor Hospital on 15 December 2023 and has been living at River View House, a residential unit since then. Dr Brown recorded on 7 May 2024: *"Overall there have been significant changes to Lucy's communication, social interaction, and emotional health and well being since she had been in care and many of her medications have been stopped without any detrimental effects"*.

The Evidence

126. I heard oral evidence from a number of nurses on Puffin Ward: Nurse Lowther, Nurse Hodson, Kylie Green, Nurse Harlow, Nurse Bridgewater, Ms Dixter (Ward Sister), Nurse Eden and Nurse Sackville. Much of their evidence is set out above in the chronology of the admission and, in very large part, their evidence simply followed the documentary evidence. In the main, they said they had little or no memory of the various incidents, which is unsurprising given the passage of time and the fact that Lucy was on the Ward for a prolonged period.

127. They all agreed that the M was a very attentive and concerned mother, who could, when she thought it necessary, be assertive in putting forward what she thought Lucy needed. Ms Evans said "she stuck up for her daughter". Ms Wisley, who the M spoke to quite a lot, said the M was concerned about Lucy's treatment and that she sometimes found it confusing with lots of different doctors. She was also worried about whether Lucy could tolerate the drugs being given via the PEG and the PEJ.

128. There was considerable evidence about how Lucy's drugs were administered. Each nurse explained that the drugs were kept in a locked medicine room. They would go into the room and fill syringes with the medication required for Lucy. The medication would be checked by a second nurse and they would then sign the chart. They each said that it was their practice to write the name of the drug on the package which the syringe was then placed in, so that whoever gave the drugs to Lucy would know which drug was which. I accept that this was the general practice, although it did become clear that there were occasions when the name was not written on the package.

129. The drug charts record the times the medicines were released from the drug room and the two nurses signed them off. They would not necessarily be given at those precise times as sometimes they were spaced out to help Lucy be able to digest them without becoming sick. The drugs were administered via different routes. Lucy had a PEG and a PEJ. She also had some drugs given intravenously.

130. The empty syringes were supposed to be placed in the clinical waste bins. It was apparent from the evidence that the empty syringes would often be left in the room for the parents to dispose of.

131. The nursing evidence suggested that at least until 11 July 2023 the parents would frequently give Lucy her medication, it having been brought through from the drugs room by the nurses. The evidence strongly suggested that often the nurses would leave the filled syringes with the parents and would then leave the room.

132. The M was adamant that she never administered the medication save under the supervision of the nurses. The F accepted that up until 13 July 2023 he did do so. I have no hesitation in accepting the nurses and the F's evidence on this point.

133. The nurses agreed that at times the parents were asked to bring things from home to help with Lucy's care. This would sometimes include medications that they had at home. Ms Harlow suggested that there were certain medications that were easier to get on prescription from the GP and a local pharmacy than for the hospital to obtain, but she was not sure which medications these were.

134. There was a good deal of inconsistency on how often and what medications were brought in. The drug chart recorded medication brought from home in pink writing completed by the pharmacist.

135. Lucy was at times in pain. The nurses could sometimes tell this because Lucy was crying, or obviously uncomfortable and agitated, but certainly Ms Evans suggested that there were times when she was led by the M saying that Lucy was in pain. Overall, a comparison of the nurses' evidence and the records suggest that quite frequently the M or F would say that Lucy was in pain where the nurses were not confident that this was the case. However, I cannot see that this discrepancy has any real bearing on the case. The M was undoubtedly very anxious and was convinced that she understood Lucy best. This may have led her to over interpret Lucy's symptoms. However, the nurses' evidence did not suggest any finding that the M was deliberately exaggerating symptoms to get more medical attention, albeit the evidence does support a finding that objectively speaking she was exaggerating Lucy's symptoms.

136. It was clear from a number of the nurses' evidence, including Ms Evans, that nursing Lucy could at times be very stressful. Ms Evans said that was because they could not "figure out what was going on". It was also apparent from a number of the nurses' evidence that working with the M and F was very difficult because relationships with many of the staff were poor and the parents had very little trust in the HCPs. The M was quick to make complaints, sometimes with some cause and other times without, and the F could be rude and aggressive at times. The text messages show that the parents distrusted and actively disliked many of the nursing staff and thought that they did not provide Lucy with good enough care, or the parents with enough support. The text messages suggest a fairly "toxic relationship" between HCPs and the parents.

137. I heard extensive evidence from nursing staff about the various unresponsive episodes, which I have summarised above. I have no reason not to accept each of the nurses' evidence at face value. In my assessment, they were all honest witnesses who did not seek to embellish their evidence. In most instances they had little recall beyond what was set out in their notes and the nursing records. Although relations with the parents were extremely strained, none of the HCP witnesses showed any animosity to the parents and there was nothing to suggest they would have made evidence up against them, let alone would have planted Chloral in the F's bag, as he suggested.

Dr Parkes

138. Dr Parkes has been a consultant paediatrician since 2003 and Deputy Medical Director at Manor Hospital since 2021. She had a brief involvement with Lucy in the week when Lucy was first admitted.

139. Dr Parkes was the Consultant of the Week during the week of 4 September 2023 and had considerable involvement during that week. On Lucy's re-admission to hospital on 5 September 2023, concerns were raised by Ms Dixter about Lucy being re-admitted so quickly and that her presentation then was similar to some of the episodes on the Ward which had given rise to concerns.

140. She said that Lucy's presentation was unusual, in that the unresponsive episodes would have much longer periods of drowsiness and low response than would have been expected. Dr King had been of the clear view that these were not typical epileptic seizures.

141. She reviewed the toxicology report that was produced on 6 September 2023, showing alcohol in Lucy's urine. A further report was produced the next day showing Ramipril in the urine.

142. Dr Parkes produced a table of all the drugs that Lucy had been prescribed and were issued in the community during the period when she was an inpatient in Manor Hospital. In particular, she pointed to the fact that 1200ml was prescribed and issued in the community whilst Lucy was in hospital. Lucy's daily prescription was 15ml, with an extra 5ml when required. Dr Parkes said that all the drugs Lucy required whilst an in-patient were available in the hospital. Although, there may have been some specific medications that were brought from home, there would have been no need for that to include Chloral or buccal midazolam.

143. Ms McGrath KC asked Dr Parkes extensively about the lack of one consultant having oversight of Lucy's care and, in particular, medication in hospital. Dr Parkes referred to Dr Brown, the community paediatrician, but accepted that Dr Brown had no responsibility for Lucy's care whilst in hospital. I note from the records that at one stage Dr Brown had told the M that the medication was difficult to change because it had been prescribed by one of the specialists in the hospital. Therefore, it is easy to see the lack of joined up oversight of Lucy's care.

144. Dr Parkes said that when Lucy was first admitted, the lead team would have been gastroenterology because she was admitted for pancreatitis. However, she effectively accepted that once the pancreatitis was dealt with, there was no clear lead team or consultant.

145. She said it was the job of the pharmacist to check the medication prescribed to see whether there were any "drug interactions", with the assistance of the British National Formulary.

146. Dr Parkes's evidence, mirrored by much of the nursing evidence (and that of Dr Jones) was that clinicians were heavily reliant on reporting by parents, particularly when a child had a neurodisability and therefore could not describe their own symptoms. Once the clinical team was in a position to observe Lucy without her parents, it was much easier to decrease the medication and monitor the impact.

147. In respect of the diagnosis of epilepsy, Dr Parkes explained that epilepsy is a condition in the diagnosis of which it can be difficult to be confident and also which can resolve over time.

148. In relation to pain, her evidence, again mirrored by others, was that there was a discrepancy between what the parents reported and what was observed on the Ward. When pain relief was decreased, there was little sign of Lucy being in pain or distress.

149. She had met the F on 15 May 2023 and she felt he had been very assertive, indeed aggressive about Lucy needing more pain relief.

Dr Jones

150. Dr Jones is a consultant general paediatrician at Manor Hospital. Dr Jones is one of the consultants in the complex care team, becoming Lucy's lead consultant after 4 September 2023. When Lucy was first admitted, she was under the care of the general paediatric team and then the gastroenterology team took over, although she was not sure when. Dr Jones had had brief involvement with Lucy when first admitted but limited involvement for a period thereafter.

151. Dr Jones said that in her experience Lucy's presentation was not typical of epileptic seizures, which were usually characterised by parts of the body twitching and tonic/clonic episodes.

152. Dr Jones said a doubt over whether the seizures were epileptic was first raised by Dr Wyatt on 15 August 2023. There had been a plan for Lucy to have a prolonged telemetry investigation, but because of lack of facilities, this was planned to take place after she had been discharged and she would have been re-admitted.

153. Dr Jones said the suggestion that Lucy was suffering from "Perplexing Presentation," i.e. that the symptoms being reported by the parents did not fit well with the professionals' observations was in late August 2023 when it was raised by Dr Renishaw.

154. Dr Jones accepted, as had Dr Parkes, that it would have been better if there had been clearer overall oversight of Lucy's case. Dr Jones accepted that the case was one of Perplexing Presentation, falling within the Royal College of Paediatrics and Child Health's Guidance. She effectively accepted that there was no discussion with the parents about the concerns about over reporting, although she said this was not a deliberate decision.

155. Ms McGrath KC asked why it had been felt appropriate to discharge Lucy even though there were such concerns about Perplexing Presentations and Safeguarding had been involved in meetings. Dr Jones said that there was not a concern at that point that the parents would harm Lucy; it was more about the overreporting and exaggeration of symptoms.

156. In respect of the quantum of medication Lucy was receiving, Dr Jones accepted that there had been no review post 2021 when this was raised by Dr Brown. She said that there was a plan to review medication at the time of discharge on 4 September 2023.

Dr King

157. Dr King is a consultant neurologist. Dr King did not give oral evidence, but produced a written statement. Dr King attended the MDT on 9 August 2023, but first saw Lucy and the M on 7 September 2023. Dr King had seen Lucy over the years before her admission in May 2023. His evidence is important because he states that, having had a lengthy description of Lucy's presentation from the nursing staff and spoken to the M about Lucy's "seizures" and unresponsive episodes, it was his view that they were very unlikely to be epileptic. Dr King considered that the medication could be contributing to her symptoms and suggested that the dosage of Baclofen in particular should be reduced.

Miss Samson

158. Miss Samson is the lead pharmacist at Manor Hospital and she put in a written statement on 13 November 2024, during the oral evidence. Miss Samson explained the process of the pharmacy staff visiting the Ward every weekday and checking, inter alia, drug interactions. There was at least one occasion when the pharmacy staff, when reviewing, found a potential interaction and recommended a change of prescription. This is all done pursuant to pharmacy Standard Operating Procedures ("SOPs").

159. The drug chart recorded drugs brought from home as "POD" (patient's own drugs). The only time Chloral was so entered was on 15 May 2023 and 23 August 2023. The only time medications were recorded as not available on the Ward were in relation to sodium docusate. There were no records of shortages of Chloral.

Evidence on Chloral Hydrate Prescriptions

160. The LA produced a note setting out the evidential position on the prescription and supply of Chloral to the parents. There was a prescription on 22 March 2023. In September 2023 the police found one bottle in Lucy's room at home, a quarter full. 600ml had been prescribed. This could have been used before Lucy was admitted on 4 May 2023.

161. On 14 April 2023, 600ml was prescribed. No bottles from this prescription were identified, but these could have been the bottles given to the hospital around the time of admission and recorded on 15 May 2023.

162. On 16 June 2023, 600ml was prescribed and was collected on 20 June 2023. One bottle was found by the police, with an expiry date of 17 September 2023. The M said that three bottles were given to the hospital on 20 August 2023, but the records do not show how much was received.

163. On 10 August 2023, a further 600ml was prescribed and collected. Three bottles were found unopened at the M's home and one was found in the F's rucksack.

164. One further bottle was located by the police at the M's home, but it was not photographed.

Expert Evidence

Dr Velayutham

165. Dr Velayutham is a consultant paediatric neurologist at Birmingham Children's Hospital. Dr Velayutham produced three reports. Unfortunately, I concluded that it was very difficult to put much weight on his evidence.

166. In his first report, dated 16 September 2024, Dr Velayutham said that he agreed with Dr Morrell that Lucy's presentation did not suggest epilepsy and the implication from his report was that the removal of the parents was key to her improvement. However, he gave little reasoning behind this conclusion. In his second report, which was a more detailed version of the first report, he said that in respect of it, it was "difficult to judge" the cause of Lucy's unresponsive episodes.

167. In oral evidence, Dr Velayutham was presented with Dr Jones's table of the medication that Lucy was on when she was an in-patient and then the points at which it was reduced/stopped. As far as I understood, his final position was that he continued to think that the combination of prescribed medication at the prescribed dosages was not responsible for the unresponsive episodes, although he accepted that many of the CNS and anti-convulsant medications could cause such episodes.

168. His reasoning for not thinking that the prescribed medications in those doses caused the episodes appeared to be that the episodes were of random duration and timing, which did not seem to relate to a standard dose.

169. Dr Velayutham was consistent in saying that he agreed with Dr King that the description of Lucy's "seizures" and unresponsive episodes did not seem likely to be epileptic. Dr Velayutham explained that epileptic seizures would generally involve physical signs, such as twitching or going rigid, which were not present. The long unresponsive episodes are not characteristic of epilepsy.

170. Dr Velayutham said that he would not expect unresponsive episodes to follow from the combination of drugs that Lucy was receiving and these were drugs that were often prescribed. However, he accepted that it was difficult to distinguish the effects of prescribed medication and an overdose of that medication and that a pharmacologist would be the best expert to consider this.

171. However, I was very concerned that Dr Velayutham referred to Lucy's electroencephalograms ("EEG"), saying he was not sure what date they were on and did not appear to appreciate that Lucy had not had either an EEG or telemetry for a number of years. Therefore, Lucy's diagnosis of epilepsy had not been confirmed through these methods for a long time. Dr Velayutham's knowledge of Lucy's history and of the notes was extremely slim. Further, the reasoning behind his conclusions and the varying of those conclusions led me to place little weight on much of his evidence. However, he was consistent that the descriptions of Lucy's unresponsive episodes did not accord with epileptic seizures.

Dr Berry

172. Dr Berry is a toxicologist. His primary evidence was about the testing of Lucy's urine sample taken on 12 August 2023 and in particular the identification of Ramipril in that sample. The testing had been done in a laboratory in the Northern General Hospital and there was no detail either on the process of the testing, nor the quantity of Ramipril found. Dr Berry had stated in his report that it would be vital to be confident that the identification of Ramipril was certain and that it would be helpful to have further testing by another laboratory to provide confidence on the testing and evidence of quantum. This was not done. It should be noted that no Ramipril was found in the hair strand testing.

173. The most important part of Dr Berry's evidence was that in his view at least trace elements of Ramipril could have transferred from the M's skin either into the urine or catheter tube, or via skin to skin contact. It was therefore at least possible that this is how the drug had got into Lucy's urine.

174. In respect of Chloral, Dr Berry said it was unusual to prescribe it for such a lengthy period. The effect of an overdose of Chloral would be to take effect quickly, as does the prescribed dose, but to make the person sleep for longer. It can increase the heart rate, although this does not happen in all patients.

175. It was in the light of this evidence that the LA withdrew its allegations around the parents giving Lucy Ramipril.

Dr Morrell

176. Dr Morrell is a consultant paediatrician. He produced four reports, which was in large part because of the piecemeal disclosure of material from Manor Hospital. He was a careful and measured witness, who had gone to great efforts to read the nursing notes and much of the medical disclosure, albeit that given the enormous amount of material he was not familiar with all of it. His written reports were detailed and balanced.

177. In respect of Lucy's diagnosis of epilepsy, Dr Morrell said that there was clear evidence of epilepsy up to 2019, by reason of a number of EEGs and telemetry investigation.

178. In respect of the unresponsive episodes between May 2023 - September 2023, Dr Morrell was of the view that this was more likely to have been caused by excessive doses of sedative medication than to be epileptic. If they were epileptic or "seizures," Dr Morrell would have expected seizure type activity, i.e. abnormal movements, jerking, stiffening of the limbs and abnormal movement of the eyes. There might also have been incontinence of urine or faeces. These symptoms were not recorded as present during the unresponsive episodes, save for a very limited reference to twitching for very short periods. Those features might continue for a period of time, but this would be limited, and would normally be only a few minutes with perhaps a maximum of 40/60 minutes.

179. However, some of Lucy's episodes were much longer than that. She was described as "floppy" which is not a feature of epileptic seizures, save for "drop attacks" which are always brief. There can be "absence seizures" but these only last for a period of seconds and the child does not lose posture.

180. He said that the nursing notes suggested that Lucy may have had some brief seizure activity, but they were never major or prolonged seizures.

181. Dr Morrell was extensively questioned on the issue of the combination of drugs that Lucy was taking through the period of her admission. In his final report, Dr Morrell reviewed the list of drugs provided by Dr Jones that Lucy had been taking during the admission. His view was that although those drugs might have caused symptoms of dizziness, drowsiness and confusion, they were unlikely to have caused the unresponsive episodes. That was because Lucy was on this combination of drugs throughout her admission and there was no reason why she should have had discrete unresponsive episodes.

182. At para 2.09 he said:

> *"2.09 I assume to explore this further, it would be necessary to examine each unresponsive episode in detail and examine whether on those days [Lucy] had received a different drug combination (or a different dose of those drugs), and the episode of unresponsiveness occurred shortly after that drug combination was given. This may be very difficult to establish unless very accurate records of the drug administrations are available".*

183. Mr Cleary took him to two periods: 19 – 22 July 2023 and 27 July – 4 August 2023, and compared the unresponsive episodes with the drug charts for those periods. There was no evidence that the relevant prescribed medication varied in any material regard between the days when Lucy did and did not have unresponsive episodes.

184. Dr Morrell said that if the unresponsive episodes were related to drug interactions then he would have expected them to occur when a particular combination of drugs was given, but this did not appear to be the case. Dr Morrell accepted in answer to Ms McGrath KC that without the very detailed analysis, which in my view would effectively now be impossible, "the possibility that the unresponsive episodes were linked to the drug combinations could not be discounted".

185. Ms McGrath KC asked him about the fact that the precise times the drugs were given is not known because the parents often gave the medication some time after they had been logged in the drugs room. However, Dr Morrell pointed out that the Chloral was prescribed to be given at 8pm, whereas many of the unresponsive episodes were much earlier than that.

186. Dr Morrell accepted that in respect of Lucy being given morphine based drugs such as Fentanyl or Oramorph for pain, it was not clear from the records when this happened (or at least not clear from the drug charts). Dr Morrell stated that if the unresponsive episodes had any relationship with morphine medications, then he would have expected them to occur very shortly after the administration and there is no evidence of this occurring.

187. Dr Morrell fully accepted that Manor Hospital had had plentiful opportunity to review the drug combination given to Lucy and had failed to do so until 9 September 2023.

188. Ms McGrath KC and Mr Roche KC put a number of possible causes of the unresponsive episodes to Dr Morrell. He said that the skull thickening which had been diagnosed in 2017 would not have caused the episodes because if intracranial pressure ("ICP") had been raised, it would have resulted in continuous rather than discrete issues; there would have been other clear indicators, such as raised blood pressure.

189. Dr Morrell was asked a number of questions about the genetic abnormality which Lucy had been diagnosed with. He accepted that the impact of this abnormality was complex and could include developmental delay and epilepsy.

190. Dr Morrell was asked whether the way that the drugs were administered, whether through the PEG or the PEJ would have impacted on their effect and therefore potentially caused unresponsive episodes. He said that would not have changed the quantum of the medication in the blood level, which is the key issue. Therefore, he discounted this as a material issue.

191. In respect of Chloral, Dr Morrell agreed that it was generally prescribed for short term use to deal with insomnia, normally for no more than 2 weeks. Dr Morrell produced a paper by Nordt and Langan (2014) on the impacts of Chloral. Mr Roche KC pointed to the passage where there is reference to Chloral having a risk of "re-sedation." Dr Morrell said that was not within his area of expertise, but it seemed rather unlikely given that Lucy was showing no signs of being sedated before the unresponsive episodes came on. The incidents of re-sedation in the paper were very limited.

192. Mr Roche KC suggested that there might be different causes for different episodes and Dr Morrell accepted that this was theoretically possible, but that did not give an explanation for any of the individual episodes.

193. At the end of Dr Morrell's evidence, I suggested that he could be asked to carry out a detailed scrutiny of the drug charts over more of the unresponsive episodes to see whether there was any unusual drug combination given at the relevant time. Ms McGrath KC and Mr Roche KC opposed this on the grounds that Dr Morrell was the wrong expert (it should be done by a pharmacologist) and that there was a lacuna in the evidence that could not be filled at this stage. I decided after hearing submissions that the forensic benefit of doing such a task would be necessarily limited because it was never going to be possible to pin down the precise time the medication was given and there was no evidence to suggest any interaction of the medication had caused any of the unresponsive episodes. I return to this in the conclusions.

The Mother

194. The M gave a number of written statements and gave oral evidence. She denied having given Lucy excessive doses of Chloral or having discussed doing so with the F. She denied any knowledge of the F doing so.

195. I have no doubt of the M's intense, perhaps over intense, love for Lucy. She described her in very moving terms and from the M's side at least, has an exceptionally strong bond with her. She clearly viewed herself as being Lucy's protector and having to fight for her. The M had constructed a very strong narrative with herself as Lucy's devoted carer and with a level of suspicion and antagonism to much of the medical staff, and in particular the nursing staff, which came close to paranoia. By the end of her evidence, I concluded I could place little reliance on much of what she said about her care of Lucy when the narrative she had created conflicted in any way with the medical professional's evidence.

196. On any analysis, Lucy has been a very sick child for many years, with a huge amount of medical intervention. There may be some truth that at times the medical care has been less than optimal. The M is, or has become, of the clear and fixed belief that only she knows what Lucy needs and is in her best interests and that she has to protect her daughter from mistakes by the HCPs. She said "as a mother I knew what was best for Lucy". The combination of Lucy's genuine medical problems, the M's anxious but unreflective personality and her conviction that the HCPs were often incompetent or worse, has led to a level of anxiety and a confrontational attitude which must have been very difficult for all concerned.

197. There was undoubtedly poor communication between the medics at Manor Hospital and the M and the F. It was only on 7 September 2023 that Dr King saw Lucy and

told the M that it was now thought that Lucy was not suffering from epilepsy. There was a long period when the medical staff seem to have been increasingly doubtful about the nature of the seizures but did not have an honest conversation with the M.

198. Throughout her oral evidence, the M was highly critical of the nursing staff, she said they were "quite slack" on the basis of a nurse topping up a feed rather than using a new feed. She said they "would not listen" when she raised issues, including on one occasion there being a double dose of paracetamol. It was not possible to tell whether either of these complaints were legitimate, but there was no word of thanks or praise for the nursing staff, who did look after Lucy for many months. The texts show a very similar story of criticism and antagonism to the staff and a belief that they were not competent and did not give the parents enough support.

199. The M accepted in oral evidence that she and the F had given Lucy medication, but said that it had always been done under the supervision of the nurses and they had never been left to give medication alone. However, the M had told the police that the nurses gave all the medications, which she accepted in oral evidence was not accurate.

200. However, the M remained adamant throughout her oral evidence that she had not given medication without the nurses supervising. There were a series of text messages which strongly implied that she and the F had at times decided when medication would be given, plainly suggesting that the nurses had not been supervising the giving of medication.

201. There is a clear conflict of evidence on this point between the M and the nurses who gave evidence. Importantly, the F, in his evidence, was clear that before 13 July 2023, he and the M did routinely give medications without the nurses being present. The F also accepted that the nurses often wrote the names of the medications on the packets. I prefer the nurses' evidence and that of the F on this point, to that of the M. I accept that the parents were routinely left to give medication. This is an important point because it is a very clear and virtually irrefutable moment when the M was not telling the truth. My perception was that the M would change her evidence to suit what she thought was to her advantage at any one time and depending on what she thought would help her case.

202. The giving of the medications is an area which exposes the M's attitude to the medical staff. It went well beyond lack of trust to outright suspicion. She said they did not write on labels unless expressly asked to and she did not know what was in the medications. In my view, this was untrue. For the majority of the time, I find the nurses did write the names on the labels.

203. The M's evidence in respect of the Chloral was confusing. The evidence was that Chloral was prescribed in the community on 14 April 2023 (600ml); 16 June 2023 (600ml) and 10 August 2023 (quantum not clear). She said that 600ml was Lucy's normal prescription, so it seems likely that the August batch was also 600ml.

204. A half full 150ml bottle was found in the F's bag (in Lucy's hospital room). This bottle was labelled 14 August 2023 and had an expiry of 9 November 2023. Four bottles of Chloral were found in the house; it seems one was from the June batch and one from the August batch.

205. The June batch expired on 17 September 2023. There was a bottle dated March 2023 found in Lucy's bedroom and one other bottle found in the bathroom, which the police photos did not show a date on.

206. The M said that she brought in 4 or 5 bottles of Chloral to Manor Hospital on 20 August 2023, which she had been asked to do by the nurses. The M gave those bottles to Nurse Sackville and Nurse Hascombe. The M accepted that this was the only time that the hospital had asked her to bring in Chloral.

207. The M initially said that April 2023 was the only time during the admission that she had ordered Chloral and she did it then because they believed they would be going on holiday with Lucy. However, the M later accepted that she had forgotten that she had collected the June batch of Chloral. The M said she had no idea what had happened to the April batch of Chloral and said it must either have been used when they were in hospital or been disposed of.

208. By the end of this evidence, I was somewhat confused as to what had happened to the April and June batches of Chloral given that Lucy had been in hospital throughout the period.

209. The M said that the texts about the dosage of Choral on 26 May 2023 and 2 June 2023 were because there had been some discrepancy between the dosage of Chloral being given by suppository and that given enterally. The M accepted that the messages in August 2023 about the dose of Chloral were because she felt Lucy was not sleeping well. The M did not however accept that she had wanted Lucy to have a higher dose of Chloral. It seems that the M was concerned that when Lucy did not sleep well, she was more likely to have seizures and this made her more anxious about Lucy's sleep.

210. When asked about the incident concerning Ms Hampton having found the F in bed with Lucy, the M rather oddly, in my view, said she thought Ms Hampton might have asked the F to get into bed with Lucy.

211. In answer to questions from Mr Roche KC, the M said on the 4 September 2023, that when they got home with Lucy, at about 2pm, she had decided to sort out the house and takes lots of stuff to the waste tip. She initially suggested this included taking medications which were out of date. When I queried this, she then said she did not remember if it included medication.

212. The M said in answer to questions from Ms Sapstead, that after the arrests in September 2023 she had asked the F if he had given Lucy unprescribed medications and he had denied doing so. The M had believed him. The M had said in her first police interview that she believed the hospital staff had given Lucy unprescribed medications. She said in oral evidence that she knew about another case (that of Mr Justice Poole) and that she did not have confidence that nurses would not "do something" to Lucy. The M cited in support that she had seen one of the nurses giving Lucy too much paracetamol (a mistake that happened on one occasion). The M "strongly believed" that the hospital had given unprescribed medication and she wanted Lucy to be safe.

213. The M accepted that in respect of the Chloral found in the F's bag that he had no reason to have it there. When the parents had been interviewed about this on 5 August

2023 the F had told her he had not put Chloral in his bag and she believed him. When the M was asked why she thought the police had found half a bottle of Chloral in the F's bag, the M said that at the time she thought that it had been "planted" by the nurses because she had told them she was going to make an official complaint and the nurses wanted to get back at her. The M said she no longer believed that and accepted that it looked as if the F had brought it in.

214. When Lucy left hospital on 4 September 2023, she said that she had given the Bluebell House key to another parent, so that that parent could move into the larger room. However, she had told the nursing staff that she had kept the key so the other parent did not get into trouble. I have to say this story made very little sense. The nursing staff were plainly suspicious that the M kept the key because she knew that they would be very swiftly returning with Lucy, which indeed is what happened.

The Father

215. The F and the M started a relationship in 2015 and he has been closely involved with the family since then. Although he and the M do not formally live in the same house, he is at her home most nights of the week.

216. In answer to questions from Ms McGrath KC the F said that he could not imagine the M doing anything to harm Lucy and that what she wanted was to get Lucy home.

217. The F accepted that he often became angry and frustrated with nursing staff. The evidence from the nursing notes paints a very clear story of the F becoming angry, aggressive and, at times, confrontational with the nurses. He explained this in oral evidence as him being frustrated with the poor communication and the way that medical plans frequently changed. There is also a clear narrative from the parents' texts of the F agreeing with the M that they knew best for Lucy and showing a real contempt and dislike for many of the nursing staff.

218. The F accepted that he and the M had disagreed with the doctors about the level of Chloral that Lucy was prescribed.

219. The F denied that the text on 12 May 2023 was him telling the M to press the button that would give Lucy Fentanyl. In my view this was an obvious lie, the texts were about Lucy's pain and it makes no sense for it to be a reference to the TV.

220. The F denied ever giving Lucy unprescribed Chloral and having his own supply in hospital. He said that the Bluebell House rooms were thoroughly searched every week and the cleaners would go through residents' bags. In my view this was a lie. Neither he nor the M had ever mentioned this before, and there is no reason why they would not have done so, given how important it is if it were true.

221. The F denied being involved or discussing the ordering of Chloral in June 2023 and said it was entirely done by the M. He said they ordered Chloral in August 2023 because they were planning to go on holiday and did not think the hospital would give it to them. He then said he was following the nurses' advice to order more Chloral, although this makes little sense because the Chloral was ordered on 10 August 2023, but there is no evidence the nursing staff asking the parents to provide it at that date.

222. The F accepted that up until 13 July 2023 the nurses would regularly give the parents medications and allow them to be given to Lucy without supervision. Interestingly, he was clear in response to questions from Ms McGrath KC that the M had given medication without supervision. He said she did so "especially" before July. He also said that on at least one occasion the M had put medication in the PEJ and then said the F had done it, so that he would get into trouble and not her.

223. In respect of 19 July 2023, the one occasion when he had suggested he was not present when Lucy became unresponsive, he initially said in his statement that he could not recall precisely where he was or the sequence of events. However, in evidence in chief he said that she was unresponsive and slumped in bed when he went into the room. But the nursing notes show that he had said to them at the time that Lucy was on her iPad. This is a clear example of the F changing his evidence to fit emerging documentary evidence. This does not accord with a fading of memory because his earliest evidence was that he did not remember.

224. There are a number of incidents recorded in the notes where the F's responses to situations seems rather odd. For example, on 6 September 2023, sitting on the bed and apparently laughing whilst Lucy was having an unresponsive episode. It was not possible to reach a view on these incidents as they could just have been a reflection of the F's personality rather than indicating anything untoward.

225. When asked about the Chloral found in his bag in the hospital by the police, the only explanation that he could put forward was that the nursing staff might have planted it because the M had had an argument with the doctors on 1 September 2023 and there had been a contact made with Social Services. He thought the nursing staff may have planted the Chloral in order to provide evidence against the parents. The M had also thought that the nurses had planted the Chloral to get the parents into trouble.

226. He accepted that he had been sent one of the child sexual abuse videos whilst with Lucy, but he said he could not remember precisely when he received it. He said he would have watched it when he returned to Bluebell House. This is only relevant because it is effectively impossible to know what was in the F's mind, and whether there is any interrelationship between his care of Lucy, the drugging of Lucy with excessive Chloral and the F's interest in Category A child sexual abuse material and exchanging highly sexualised texts with other people about the sexual abuse of young children. The F's evidence took the Court no further on this issue. It remains a "known unknown".

227. I do however note that at every possible point the F sought to minimise his actions. He denied watching the videos sent to him on 7 September, which is possible but unlikely. He said he could not remember the highly sexualised and abusive texts he sent on the Kik platform on 3 September. He denied not wearing a top in the video of Lucy from 2021 and said he had always been fully clothed, whereas I have watched the video and it is reasonably apparent he is not wearing a top. This all leads to a conclusion that I can put very little weight on the F's evidence.

228. My sense of the F was that he was quite prepared to lie to the court when it was in his interests and he thought he could get away with it.

229. In relation to the child sexual abuse material the F said that the M had not known that he was watching it or that he was texting other people about child sexual abuse on the Kik platform.

The law

230. The law in this field is not in itself contentious. I will adopt the passage from Poole J's judgment in *BR and others (Three Families: Fabricated or Induced Illness: Findings of Fact)* [2023] EWFC 326:

> *"21. The judgments of Baker J in A Local authority and (1) Mother (2) Father (3) L & M (Children, by their Children's Guardian) [2013] EWHC 1569 (Fam) and Peter Jackson J in Re BR (Proof of Fact) [2015] EWFC 41 are of particular assistance in guiding the court's approach to a finding of fact hearing. More recently, MacDonald J summarised the principles to be applied in Re A Local Authority v W and others [2020] EWFC 68 . I derive the following principles from those cases and the authorities that those judges reviewed:*
>
> *a. The burden of proof lies on the Local Authority that brings the proceedings and identifies the findings they invite the court to make. There is no obligation on a respondent to provide or prove an alternative explanation.*
>
> *b. The standard of proof is the balance of probabilities, Re B [2008] UKHL 35. If the standard is met, the fact is proved. If it is not met, the fact is not proved. As Lord Hoffman observed in Re B:*
>
> *"If a legal rule requires facts to be proved, a judge must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are nought and one."*
>
> *c. There is no burden on a parent to produce an alternative explanation and where an alternative explanation for an injury or coHallete of conduct is offered, its rejection by the court does not establish the applicant's case.*
>
> *d. The inherent probability or improbability of an event should be weighed when deciding whether, on balance, the event occurred but regard to inherent probabilities does not mean that where a serious allegation is in issue, the standard of proof required is higher.*
>
> *e. Findings of fact must be based on evidence not suspicion or speculation - Lord Justice Munby in Re A (A child) (Fact Finding Hearing: Speculation) [2011] EWCA Civ 12 .*
>
> *f. The court must take into account all the evidence and consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss, President observed in Re T [2004] EWCA Civ 558, [2004] 2 FLR 838 at paragraph 33 :*

"Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to the other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion of whether the case put forward by the Local Authority has been made out to the appropriate standard of proof."

g. The opinions of medical experts need to be considered in the context of all the other evidence. In A County Council v KD & L [2005] EWHC 144 Fam at paragraphs 39 to 44, Mr Justice Charles observed:

"It is important to remember that (1) the roles of the court and the expert are distinct and (2) it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. The judge must always remember that he or she is the person who makes the final decision."

h. Later in the same judgment, Mr Justice Charles added at paragraph 49:

"In a case where the medical evidence is to the effect that the likely cause is non-accidental and thus human agency, a court can reach a finding on the totality of the evidence either (a) that on the balance of probability an injury has a natural cause, or is not a non-accidental injury, or (b) that a local authority has not established the existence of the threshold to the civil standard of proof ... The other side of the coin is that in a case where the medical evidence is that there is nothing diagnostic of a non-accidental injury or human agency and the clinical observations of the child, although consistent with nonaccidental injury or human agency, are the type asserted is more usually associated with accidental injury or infection, a court can reach a finding on the totality of the evidence that, on the balance of probability there has been a non-accidental injury or human agency as asserted and the threshold is established."

i. The evidence of the parents and any other carers is of the utmost importance. They must have the fullest opportunity to take part in the hearing and the court must form a clear assesLucyent of their credibility and reliability.

22. It is not uncommon for witnesses in these cases to tell lies in the coHallete of the investigation and the hearing. The court must be careful to bear in mind that a witness may lie for various reasons, such as shame, misplaced loyalty, panic, fear, distress and the fact that the witness has lied about some matters does not mean that he or she has lied about everything: see R v Lucas [1981] QB 720 . In the recent Court of Appeal judgment in A, B, and C (Children) [2021] EWCA 451, Macur LJ advised at [57],

"I venture to suggest that it would be good practice when the tribunal is invited to proceed on the basis, or itself determines, that such a direction

is called for, to seek Counsel's submissions to identify: (i) the deliberate lie(s) upon which they seek to rely; (ii) the significant issue to which it/they relate(s), and (iii) on what basis it can be determined that the only explanation for the lie(s) is guilt. The principles of the direction will remain the same, but they must be tailored to the facts and circumstances of the witness before the court."

Similar caution should be exercised in relation to a respondent giving unsatisfactory explanations or failing to give any explanation for the allegations made against them – the fact that they are unsatisfactory or missing may not be probative of the truth of the allegations or of the culpability of the respondent.

23. As observed by Dame Elizabeth Butler-Sloss President in Re U, Re B [2004] EWCA Civ 567 supra "The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research may throw a light into corners that are at present dark". In Re R (Care Proceedings: Causation) [2011] EWHC 1715 Fam Mr Justice Hedley, developed this point further at paragraph 19:

"... there has to be factored into every case which concerns a discrete aetiology giving rise to significant harm a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities."

24. In The Popi M, Rhesa Shipping Company SA v Edmunds [1985] 1 WLR 948 , Lord Brandon considered an appeal from the first instance judgment of Bingham J upon the question of whether a ship had been lost due to "perils of the sea", a matter which the owners had to establish. The owners contended that the vessel had been lost due to a collision with a submarine. The underwriters contended that the loss was due to wear and tear. In his well-known judgment Lord Brandon stated as follows,

"The passages which I have quoted from Bingham J.'s judgment amply support the observations about his approach to the case which I made earlier. These observations were to the effect that he regarded himself as compelled to make a choice between the shipowners' submarine theory on the one hand and underwriters' wear and tear theory on the other, and he failed to keep in mind that a third alternative, that the shipowners' had failed to discharge the burden of proof which lay on them, was open to him.

As regards the shipowners' submarine theory, Bingham J. stated in terms that he regarded it as extremely improbable, a view with which I think it unlikely that any of your Lordships will quarrel. As regards underwriters' wear and tear theory, ... he regarded the wear and tear

theory not as impossible, but as one in respect of which any mechanism by which it could have operated was in doubt.

My Lords, the late Sir Arthur Conan Doyle in his book "The Sign of Four", describes his hero, Mr. Sherlock Holmes, as saying to the latter's friend, Dr. Watson: "how often have I said to you that, when you have eliminated the impossible, whatever remains, however improbable, must be the truth?" It is, no doubt, on the basis of this well-known but unjudicial dictum that Bingham J. decided to accept the shipowners' submarine theory, even though he regarded it, for seven cogent reasons, as extremely improbable.

In my view there are three reasons why it is inappropriate to apply the dictum of Mr. Sherlock Holmes, to which I have just referred, to the process of fact-finding which a judge of first instance has to perform at the conclusion of a case of the kind here concerned.

The first reason is one which I have already sought to emphasise as being of great importance, namely, that the judge is not bound always to make a finding one way or the other with regard to the facts averred by the parties. He has open to him the third alternative of saying that the party on whom the burden of proof lies in relation to any averment made by him has failed to discharge that burden. No judge likes to decide cases on burden of proof if he can legitimately avoid having to do so.

There are cases, however, in which, owing to the unsatisfactory state of the evidence or otherwise, deciding on the burden of proof is the only just course for him to take.

The second reason is that the dictum can only apply when all relevant facts are known, so that all possible explanations, except a single extremely improbable one, can properly be eliminated. That state of affairs does not exist in the present case ...

The third reason is that the legal concept of proof of a case on a balance of probabilities must be applied with common sense. It requires a judge of first instance, before he finds that a particular event occurred, to be satisfied on the evidence that it is more likely to have occurred than not. If such a judge concludes, on a whole series of cogent grounds, that the occurrence of an event is extremely improbable, a finding by him that it is nevertheless more likely to have occurred than not, does not accord with common sense. This is especially so when it is open to the judge to say simply that the evidence leaves him in doubt whether the event occurred or not, and that the party on whom the burden of proving that the event occurred lies has therefore failed to discharge such burden.

In my opinion Bingham J. adopted an erroneous approach to this case by regarding himself as compelled to choose between two theories, both of which he regarded as extremely improbable, or one of which he regarded as extremely improbable and the other of which he regarded as virtually impossible. He should have borne in mind, and considered

carefully in his judgment, the third alternative which was open to him, namely, that the evidence left him in doubt as to the cause of the aperture in the ship's hull, and that, in these circumstances, the shipowners had failed to discharge the burden of proof which was on them."

25. Re SB (Children) [2009] EWCA Civ 1048 confirms that the test for identifying a perpetrator of harm to a child is the balance of probabilities "nothing more and nothing less". There are many potential advantages in identifying the perpetrator of non-accidental injuries but the court should not "strain to find a perpetrator" and sometimes the task is impossible, Re D (Care proceedings: Preliminary hearing) [2009] 2 FLR 668 . In an appropriate case the court should identify the "pool" of potential perpetrators of significant harm applying the test of "real possibility" North Yorkshire CC v SA [2003] 2 FLR 849 .

26. Witnesses at this hearing gave evidence in a large courtroom and were questioned by up to twelve Counsel as well as the Judge. Tailored warnings under s98 of the Children Act 1989 were given to the parents. Those warnings add to the pressure on the parents, in particular the mothers in this case who are facing possible criminal charges. Macur LJ in Re M (Children) [2013] EWCA Civ 1147 at [11] and [12] , cautioned that,

"Any judge appraising witnesses in the emotionally charged atmosphere of a contested family dispute should warn themselves to guard against an assessment solely by virtue of their behaviour in the witness box and to expressly indicate that they have done so".

I have heeded that warning. In Lancashire County Council v M and F [2014] EWHC 3 (Fam) Peter Jackson J made the following observations which are pertinent to the present cases,

"To these matters I would only add that in cases where repeated accounts are given of events surrounding injury and death, the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record keeping or recollection of the person hearing or relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as " story-creep " may occur without any necessary inference of bad faith."

27. As discussed earlier in this judgment, Munchausen Syndrome by Proxy is no longer the preferred term in the UK for the phenomenon

alleged to have resulted in harm to the three children with whom I am primarily concerned. The term now used is Fabricated or Induced Illness. However, the warning given by Ryder J in A County Council v A mother and others [2005] EWHC 31 (Fam) at [175] to [178] applies to the present case,

"The terms 'Munchausen Syndrome by Proxy' and 'Factitious (and Induced) Illness (by Proxy)' are child protection labels that are merely descriptions of a range of behaviours, not a paediatric, psychiatric or psychological disease that is identifiable. The terms do not relate to an organised or universally recognised body of knowledge or experience that has identified a medical disease (i.e. an illness or condition) and there are no internationally accepted medical criteria for the use of either label.

In reality, the use of the label is intended to connote that in the individual case there are materials susceptible of analysis by paediatricians and of findings of fact by a court concerning fabrication, exaggeration, minimisation or omission in the reporting of symptoms and evidence of harm by act, omission or suggestion (induction). Where such facts exist the context and assessments can provide an insight into the degree of risk that a child may face and the court is likely to be assisted as to that aspect by psychiatric and/or psychological expert evidence.

…

In these circumstances, evidence as to the existence of MSBP or FII in any individual case is as likely to be evidence of mere propensity which would be inadmissible at the fact finding stage (see Re CB and JB supra). For my part, I would consign the label MSBP to the history books and however useful FII may apparently be to the child protection practitioner I would caution against its use other than as a factual description of a series of incidents or behaviours that should then be accurately set out (and even then only in the hands of the paediatrician or psychiatrist/psychologist). I cannot emphasise too strongly that my conclusion cannot be used as a reason to re-open the many cases where facts have been found against a carer and the label MSBP or FII has been attached to that carer's behaviour. What I seek to caution against is the use of the label as a substitute for factual analysis and risk assessment."

28. In cases of alleged FII the court will often be tasked with considering whether the evidence establishes a pattern of behaviour on the part of the respondent parent demonstrating their character and propensity to harm their child. Must each individual element of that pattern be proved on the balance of probabilities? In R v P (Children: Similar Fact Evidence) [2020] EWCA Civ 1088 the court considered that the approach to similar fact evidence taken in O'Brian v Chief Constable of South Wales Police [2005] UKHL is applicable to civil (and family) cases.

"Where the similar fact evidence comprises an alleged pattern of behaviour, the assertion is that the core allegation is more likely to be true because of the character of the person accused, as shown by conduct on other occasions. To what extent do the facts relating to the other occasions have to be proved for propensity to be established? That question was considered by the Supreme Court in the criminal case of R v Mitchell [2016] UKSC 55 [2017] AC 571 , where it was said that the defendant, who was charged with murder by stabbing, had used knives on a number of other occasions, none of which had led to a conviction but which on the prosecution's case showed propensity. Lord Kerr addressed this issue in the following way:

"Propensity - the correct question/what requires to be proved?

39. A distinction must be recognised between, on the one hand, proof of a propensity and, on the other, the individual underlying facts said to establish that a propensity exists. In a case where there are several incidents which are relied on by the prosecution to show a propensity on the part of the defendant, is it necessary to prove beyond reasonable doubt that each incident happened in precisely the way that it is alleged to have occurred? Must the facts of each individual incident be considered by the jury in isolation from each other? In my view, the answer to both these questions is "No".

43. The proper issue for the jury on the question of propensity… is whether they are sure that the propensity has been proved. ... That does not mean that in cases where there are several instances of misconduct, all tending to show a propensity, the jury has to be convinced of the truth and accuracy of all aspects of each of those. The jury is entitled to - and should - consider the evidence about propensity in the round. There are two interrelated reasons for this. First the improbability of a number of similar incidents alleged against a defendant being false is a consideration which should naturally inform a jury's deliberations on whether propensity has been proved. Secondly, obvious similarities in various incidents may constitute mutual corroboration of those incidents. Each incident may thus inform another. The question ... is whether, overall, propensity has been proved.

44. ... the jury should be directed that, if they are to take propensity into account, they should be sure that it has been proved. This does not require that each individual item of evidence said to show propensity must be proved beyond reasonable doubt. It means that all the material touching on the issue should be considered with a view to reaching a conclusion as to whether they are sure that the existence of a propensity has been established."

26. Again, this analysis is applicable to civil and family cases, with appropriate adjustment to the standard of proof. In summary, the court must be satisfied on the basis of proven facts that propensity has been proven, in each case to the civil standard. The proven facts must form a

> *sufficient basis to sustain a finding of propensity but each individual item of evidence does not have to be proved."”*

231. Ms McGrath KC in her Closing Submissions emphasised the caselaw that makes clear that there is no burden on the parents in this type of litigation and it is important not to impose some kind of “pseudo-burden”: Mostyn J, in *Lancashire v R* [2013] EWHC 3064 (Fam); Keehan J in *Wolverhampton City Council v JA & Ors* [2017] EWFC 62; Munby J in R*e X (no.3)* [2015] EWHC 3651 (Fam) and *Re Y no.3* [2016] EWHC 503 (Fam); HHJ Bellamy in *Re FM (a child: Fractures, Bone Density)* [2015] 3 WLUK 346.

232. In respect of identifying a perpetrator, reliance should be placed upon King LJ in *Re A* [2022] EWCA Civ 1348:

> *“34. I suggest, therefore, that in future cases judges should no longer direct themselves on the necessity of avoiding "straining to identify a perpetrator". The unvarnished test is clear: following a consideration of all the available evidence and applying the simple balance of probabilities, a judge either can, or cannot, identify a perpetrator. If he or she cannot do so, then, in accordance with Re B (2019), he or she should consider whether there is a real possibility that each individual on the list inflicted the injury in question.”*

The Submissions

233. Mr Cleary relies on the evidence of the three expert witnesses as set out above, albeit he accepted that limited weight should be placed on Dr Velayutham’s evidence. Taking all the expert evidence together, Mr Cleary says it proves that the unresponsive episodes were not related to epilepsy; were not caused by the prescribed level of medication either alone or in combination; if they had been from the prescribed medication there would have been a pattern relating to that medication, which is not the case; were consistent with an overdose of Chloral; the different lengths of unresponsive episodes were consistent with different levels of Chloral and were likely to have been caused by the overdosing with a sedative medication such as Chloral.

234. Mr Cleary refuted the suggestion that there was a lacuna in the evidence, for reasons that I accept and set out below in my conclusions.

235. Mr Cleary accepted that the overall improvement in Lucy’s presentation after 7 September 2023 may have related to the change in her medication, but that does not support a finding that the unresponsive episodes stopped for the same reason. Dr Morrell’s evidence was that there were two separate issues.

236. In respect of the unresponsive episodes, Mr Cleary pointed to the strong links between the presence of the F, and sometimes the M, and the episodes, and the fact there were no episodes when Lucy was on 1:1 nursing. He went through the individual episodes, and I have set out the relevant points above in the chronological section. Mr Cleary relied on various factual points which I refer to below.

237. In respect of motivation, Mr Cleary pointed to the parents' frustration with the medical professionals and the texts which suggested that the F was encouraging the M to press the NCA button for fentanyl without medical approval. He also relied on the F's viewing of child sexual abuse material as possibly exposing an enjoyment of Lucy being unwell.

238. In respect of the M, the LA accepts that there were a number of occasions when she was not present and therefore she could not alone have administered Chloral. However, she was aware that the F was administering Chloral, as is evidenced by the texts and various other matters, such as the ordering of excessive amount of Chloral.

239. The M's case is largely set out in the summary of her evidence set out above. Ms McGrath KC emphasises that there were a number of unresponsive episodes when the M was not present and could not herself be responsible for having administered Chloral. In respect of alleged collusion with the F, the burden of proof is on the LA to prove such collusion.

240. She submits that the M had no possible motivation for overdosing Lucy on Chloral. She was a loving mother with a history of being highly protective of Lucy. To the degree that she was hyper-vigilant, anxious and assertive with hospital staff, she had every cause to be. Ms McGrath KC points to various alleged failures by Manor Hospital, including the lack of lead paediatrician, no MDT meetings until very late in the admission, and no review of Lucy's medication until 7 September 2023. The treatment and medication was based on a diagnosis of epilepsy, of which no clinical tests had been carried out since 2019. The nursing staff were highly suspicious of the parents from the outset of the admission and the M's concerns about feeding, pain relief and oxygen were treated with intense suspicion by the HCPs.

241. There was a breach of the Royal College of Paediatrics and Child Health guidance in respect of the unresponsive episodes being Perplexing Presentations because there was no attempt by the hospital staff to engage with the parents before Lucy was discharged.

242. Ms McGrath KC strongly emphasises the caselaw about the burden of proof being on the LA, rather than there being any burden on the parents to disprove the LA case.

243. In respect to the text messages, Ms McGrath KC relies on a large number of other text messages which confirm the M's commitment to ensuring that Lucy has the best quality of life and how much she wanted Lucy to be able to go home.

244. Ms McGrath KC submits that there was a lacuna in the LA case in respect of the unresponsive episodes being caused by a combination of the medication because Dr Morell was not a pharmacologist and, in any event, the drugs chart does not provide an accurate record of the precise times that drugs were administered. Therefore, the LA could not establish that the cause of the unresponsive episodes was an overdose of Chloral as opposed to the combination of medication that she was on.

245. Mr Roche KC's submissions are largely similar to those of Ms McGrath KC and in large part I deal with them in the conclusions. Mr Roche KC relies on the possibility that the unresponsive episodes were caused by the combination of medication and on

the paper by Nordt on the risk of re-sedation with Chloral. He relies on the lack of a pharmacological expert.

246. Mr Roche KC urged the Court to consider each episode separately, which is set out above. I note here that some of the episodes differ, for example when Lucy did respond to Buccal Midazolam. However, that is a matter that Dr Morrell dealt with.

247. In respect of Ms Sapstead's submissions, again these were largely similar to those of the LA. Her analysis of the expert evidence is, to a considerable extent, mirrored in what I have set out above.

248. Ms Sapstead undertook a detailed analysis of the various lies that the parents had told to the court and in their oral evidence. This was a very useful exercise which I have heavily relied upon in my conclusions below.

249. Ms Sapstead's position was that relying on *Re A* [2022] it is not possible to single out one perpetrator between the parents. Although the M was not present for some of the episodes, she had been reluctant over a prolonged period to reduce Lucy's medication. The M has showed a remarkable lack of curiosity over a number of incidents, and actively sought to mislead the court on a number of issues.

Conclusions

250. The central allegation in this case is that the parents, whether together or separately, gave Lucy excessive doses of Chloral which caused the unresponsive episodes. The case is undoubtedly complex because of Lucy's very serious underlying conditions and the very extensive list of medications that she was on from May 2023 – September 2023 and which were then varied at the same time as the parents being removed from her care.

251. In reaching conclusions, I have had closely in mind the principles applicable to a finding of fact decision, as succinctly set out by Baker J in *A Local authority and (1) Mother (2) Father (3) L & M (Children, by their Children's Guardian)* [2013] EWHC 1569 (Fam).

252. Critically in this case, the burden of proof is on the LA at all times and the standard of proof is the balance of probabilities.

253. It is important to be clear what this case is not about. Extensive time was spent on the quality of care and in particular the level of medical oversight that Lucy was receiving at Manor Hospital. This case is not an investigation into the quality of care at Manor Hospital. I accept, as I think did Dr Parkes, that there was a lack of clear medical lead and oversight during Lucy's admission up to early September 2023. Lucy was initially admitted with pancreatitis, so the gastroenterology team led, but after the pancreatitis receded there does not appear to have been a clear clinical lead. The list of consultants who had some role in Lucy's care was a very long one and the need for better oversight was manifest. It is hardly surprising in this situation that the parents became confused and at times frustrated.

254. With the benefit of hindsight, this problem was particularly acute around Lucy's diagnosis of epilepsy and her medication. Doubts over whether she really did still

have epilepsy and about the medication featured through much of the admission, but nobody seems to have taken ownership and control of this issue. It is somewhat surprising that her consultant neurologist, Dr King, did not see her until early September and it was only at that point that the medication was changed. It was reasonable for the parents to continue to believe that she did suffer from epilepsy and needed the medication given that there had been no clinical review and they had not been told that the doctors now doubted the diagnosis.

255. However, these issues with the quality of care do not directly relate to the alleged facts that I have to determine. They do support a conclusion that the parents had little trust in the medical staff, were unclear as to the treatment plan and felt that they were the people who best knew what Lucy needed.

256. The broader evidence also supports a conclusion that relations between the nursing staff and the parents were very poor. Both parents originally told the police that they thought the nurses had planted Chloral in the F's bag because the M had threatened to make a formal complaint against them. Although the M did not pursue this allegation during the hearing, the F did (albeit it was not directly put to any of the nurses). This showed a level of hostility by the parents which is unusual.

257. The evidence on the unresponsive episodes can be divided into two parts – the medical evidence and the factual evidence.

258. As I have said above, I place somewhat limited weight on Dr Velayutham's evidence given his lack of investigation of the records relating to Lucy's diagnosis of epilepsy. However, I have no reason to doubt his evidence in respect of general neurology. He said that Lucy's presentation and the unresponsive episodes do not seem like epilepsy. He certainly thought that being overdosed with prescribed medication was a possible cause of the episodes, but given the changes in his view during the oral evidence, I do not think I can safely put any great reliance on his view of causation either way.

259. Dr Berry agreed that if someone was given a larger than normal dose of Chloral then it would make them unconscious for a period of time and the length would depend on the dose. He also said that there was a narrow therapeutic window between a normal dose and an overdose. This evidence supports a finding that Chloral was a cause of the unresponsive episodes, although it is very far from being determinative. It also might explain the considerable difference between the lengths of the different unresponsive episodes.

260. Dr Morrell's evidence was that the unresponsive episodes were not consistent with epileptic seizures. If they had been caused by a combination of the prescribed medications, then it would be expected that they would occur each time that combination was given. It was unlikely that was the cause because of the way the episodes came on, directly from when Lucy was well and alert. His view was that doing the same analysis on the days of every unresponsive episode was unlikely to "yield anything".

261. His view was that in the absence of any evidence that the combination of medications caused the unresponsive episodes, the likely cause was the administration of a sedative drug, such as Chloral, in excess of the prescribed amount.

262. Mr Roche KC and Ms McGrath KC submitted that there was a lacuna in the evidence because no detailed analysis was undertaken on each unresponsive episode and the medication given, and the exercise was not done by a pharmacologist. However, Dr Morrell did do that exercise for three of the unresponsive episodes and found no change in the medication which would give any reason for the unresponsive episode. I suggested that he could be asked to do the same exercise for the other episodes but no advocate invited me to follow that course.

263. In my view, there is no lacuna in the evidence here. Dr Morrell was appointed as the Single Joint Expert, is a very experienced paediatrician and gave very carefully reasoned evidence. The effect of a combination of medication on a child with Lucy's conditions fell well within his expertise. No party had applied under Part 25 for a pharmacological witness. Further, the pharmacologist at Manor Hospital had kept regular oversight on Lucy's medication and did not indicate any concern about the combination of medications that she was given. Given that three episodes were examined in detail and gave no support for the argument, and there is nothing to suggest a pattern between the prescribed medication and the unresponsive episodes, there is no lacuna by not examining all the other episodes.

264. Mr Roche KC raised the possibility that Lucy had suffered from "re-sedation" as was referred to in the paper produced by Dr Morrell. However, there was no evidence to support this thesis. It was no more than a possibility raised by an advocate, but not supported by Dr Morrell or any other witness. Given the lack of any pattern between the giving of prescribed Chloral and the unresponsive episodes, it seems an unlikely link in any event.

265. The unresponsive episodes stopped after 5 September 2023. The parents were arrested on 7 September 2023, so were removed from Lucy's care but there was also a significant change to her medication and very shortly thereafter a significant improvement in her presentation. Dr Morrell considered that there were two different things happening here. The improvement to Lucy's general presentation was probably caused by the change and reduction to her medication. However that was separate from the cessation of the unresponsive episodes. Given the expert evidence, and the overall factual position, I accept Dr Morrell's evidence on this.

266. I turn to the broader evidential canvas. Firstly, the evidence of the timing of the unresponsive episodes. There were no episodes when Lucy was on 1:1 nursing care, nor after the parents were removed from her care. In respect of the 1:1 care period, there is no evidence of any change of medication or any other factor which would explain this coincidence of timing.

267. All the unresponsive episodes occurred when either or both of the parents were present. The detail of the timings is set out above. It is undoubtedly the case that there are a number of episodes when the M was not present and therefore it is not possible that she was administering overdoses of Chloral on those occasions. On my analysis of the facts, as set out above, the F was present on each occasion at a point that he could have administered Chloral to Lucy.

268. Secondly, there are a number of messages between the parents that support a finding that they had their own Chloral supply. The messages are set out above on 2 June 2023 and 8 June 2023. These are but a very small number of messages in a huge

amount of electronic communication. I accept that the vast majority of that communication suggests concerned and loving parents. However, the messages are hard to understand if they were not about the parents having Chloral and considering using it. This is in the context of now knowing that the parents did have large quantities of Chloral at home, which they had collected from prescriptions. I do not put much weight on the use of the word "the" Chloral bottle on 8 June 2023. This might just have been related to the auto-correct feature.

269. Thirdly, is the now established fact that the parents had a large amount of Chloral at home. The details of this are set out above, but the evidence is clear that a large amount of the Chloral is unaccounted for. The parents gave rather inconsistent accounts of the reasons for continuing to get prescriptions of Chloral when medication was given at the hospital on discharge and if they went on holiday.

270. I accept that there could be an element of confusion over this between the parents, and perhaps they had got into the habit of stockpiling medication. However, this evidence does strongly suggest that the parents wanted a very large amount of Chloral (a two month supply) within their possession for no very clear reason.

271. Fourthly, is the half full bottle of Chloral found in the F's bag in the hospital. The bottle was 150ml and had been issued on 14 August 2023. The M had said the Chloral that they took into hospital on or around 20 August 2023 was the June prescription as they were near their expiry date. The F said they took into the hospital the August prescription and one of the nurses must have planted it in his bag to "frame" him. The F named Ms Kew and Ms Hascombe as possible candidates. I dismiss this as a possibility. This would be an extraordinary thing for them to do and the possibility that the M would make a complaint would give no basis for the nurses to plant Choral. In these circumstances, neither parent can give any explanation as to how the Chloral ended up in the F's bag.

272. Fifthly, is the syringe wrapper found by the police in the F's car. There is no reason for a syringe to be brought from home to the hospital. This was some months after the parents say they stopped giving medication unsupervised. The parents say the syringe wrapper must have been part of the waste that that they took to the tip the day Lucy was discharged. I find it beyond odd that on the day Lucy went home for the first time in three months, they decided to leave her with Janine and go to the tip.

273. Sixthly, both parents undoubtedly lied on a number of points. I am very conscious of the guidance in *Lucas* (*R v Lucas* [1981] QB 720) and that people may lie about something for a wide range of reasons which do not mean that they are lying about the issues in the case.

274. The M definitely lied about not giving medication to Lucy without the supervision of the nurses. I am sure she did this to distance herself from the giving of the medication, and therefore any suggestion that she or the F had been responsible for overdosing Lucy on Chloral. It is possible, although in my view somewhat unlikely, that she lied about this to try to protect herself from the allegations, even though they were untrue. The M has shown herself to be quite astute at answering questions and working out scenarios that help her in the case. If she was innocent of the allegations, it is more than surprising in the light of all the evidence that she did not accept that she and the

F had been giving medication unsupervised up to 13 July 2023 and after 1 September 2023.

275. Associated to this is that the M lied about the syringe wrappers being labelled. The evidence is overwhelming that the nurses normally did this. I simply do not believe that the M forgot this was the case. She was trying to shift blame for any overdoses onto poor nursing practice.

276. I also think that the M lied about not sanitising her hands when catheterising Lucy. She told the police that she did hand sanitise and Ms Heligan said in oral evidence when this issue was first raised, that the M would have washed her hands. It would be bizarre for the M not to have washed or sanitised her hands when catheterising Lucy, particularly in circumstances where she often suffered from infection so there would be a very obvious risk. In my judgement, she told this lie to convince the court that the sample could have been contaminated.

277. The F lied about the message on 12 May 2023 when he was clearly telling the M to press the button for Fentanyl. The suggestion that "itv" was referring to the remote TV button makes no sense and is plainly untrue.

278. The F lied about not being in the room on 19 July 2023 when Lucy started an unresponsive episode. Ms Harlow's evidence was clear, as was the nursing note (the details are set out in the chronology section) and the F quickly reverted in cross examination to saying he could not remember the precise sequence of events. The very obvious reason for this lie was to establish one unresponsive episode when the F was not present at the outset of the episode.

279. Both parents told a series of different versions about the bottles of Chloral that had been ordered and collected from the community pharmacy. The detail of the orders and the version of events are set out above. I accept that memories may have faded and there was so much going on that the parents might have become confused. However, as was set out by Ms Sapstead in her Closing Submissions, the M in particular gave a very clear account to the police and then a different account to the Court when it became obvious that the original version could no longer stand. Both in respect of the June and August batches, the M told wholly different stories to the police and then to the Court.

280. There are two aspects of this that I find particularly important. Firstly, all the objective evidence shows the parents stockpiling large quantities of Chloral when it was palpably not necessary. The most obvious reason for this was that they wanted to be in a position to give Chloral to Lucy in the hospital when it was not prescribed. Although some confusion over dates and quantities might be unsurprising, there is a very strong pattern here of the parents telling one story until they can see it is no longer sustainable. Secondly, there is simply no explanation given for the half bottle of Chloral found in the F's bag.

281. I also think the parents were not telling the truth about taking the Bluebell House key. The M told the Court that she had given it to her friend Jackie so that Jackie could get the larger room and that she had lied to the nurses about taking the key home to protect Jackie. This story made no sense. It would be obvious to anyone that Jackie could not simply move into a larger room, particularly if the F's evidence that rooms

were regularly checked was true. In any event, there is no reason why Jackie would have lost her room given that her child was sick and in the ICU.

282. In my view, the M made up this story to cover the fact that for whatever reason she was expecting or hoping to return to hospital.

283. I also think that the F lied about Bluebell House rooms being regularly searched. He had never previously mentioned this and when I asked him why not, he said he "did not realise it was relevant". It was obviously relevant and if it had been true, either he or the M would have previously relied upon it. This was a transparent attempt to avoid blame for the Chloral being found in the room. It is very hard to find any alternative explanation for this lie, other than guilt about having the supply of Chloral.

284. Ms Sapstead also relies on the F's lies about not watching child sexual abuse images. However, it is very obvious why the F would have lied about this until the evidence was incontrovertible. This is a serious criminal offence, as well as being morally repugnant. His lies about the child sexual abuse material, therefore in my view, do not support a finding about his credibility on the wider evidence.

285. In my view, the strongest argument against finding that the parents, whether together or separately, gave Lucy overdoses of Chloral is trying to understand why they would have done so. I accept the M was a loving M who was totally devoted to Lucy and wanted what she perceived to be in her best interests. I also accept that the F had acted as Lucy's father for many years and had an apparently loving relationship with her.

286. In a case such as this, it is very difficult to determine motivation in the absence of concessions or any psychological evidence. I am loathe to speculate too far on possible motivation. However, given that Ms McGrath KC submits strongly that it would be extraordinary for a loving and protective mother to be harming her child by overdosing on Chloral, I have to address this issue.

287. The evidence is that the M and F were totally sure that they knew what was best for Lucy. They had, during this admission, almost no faith in the HCPs and indeed thought at times that the HCPs were harming Lucy. Their lack of trust in, and indeed contempt for, the nursing staff and the doctors, shines through from the extensive texts I have been referred to. The texts and broader evidence suggests that the parents thought Lucy needed more Chloral and that it would help her epilepsy to sleep more. They were extremely frustrated with the HCPs not giving more pain and sleeping medication. It may well be that the parents did not think that they were harming Lucy by giving her extra Chloral, but rather that they were helping her.

288. There is also some evidence of the F either enjoying Lucy being seriously unwell, or at least being unconcerned. He certainly seems to have been remarkably unworried about her unresponsive episodes if they were genuinely as mysterious as the HCPs thought they were.

289. It is also extremely difficult to work out the dynamics of the relationship between the parents. The M has in the past failed to protect her children during a relationship with the older children's father, and was plainly exceptionally difficult for the professionals to work with. The M and the F seem to have established a narrative of themselves acting together against the professionals in Lucy's best interests. Where

that took them in their private discussions is impossible to tell. Equally, the relationship (if the M is to be believed) was one where the F was watching the most serious child sexual abuse material and frequently communicating with people about extreme child sexual abuse fantasies and the M had no knowledge of this. So, there were elements of emotional reliance mixed in with deceit that may have led to a complex dynamic between the parents.

290. That the F enjoyed, if that is the right word, child sexual abuse material is incontrovertible. The photos of Lucy are not self-evidently sexual, although that does not mean that the F did not find them so. How the F's interest in child sexual abuse material and his sometimes odd behaviour around Lucy, relate to the overdosing of Chloral, is an issue which I feel is outside the scope of this judgment.

291. It is correct that many of the unresponsive episodes took place at times when the M was not present and could not have given the Chloral. Equally, there are texts at the time of some of the episodes which suggest the M genuinely did not know what had happened. However, I find that the F did give the Chloral overdoses and the evidence clearly supports such a finding. In the light of the overall evidence, including the detailed chronology, the texts, the lies, and the stockpiling of Chloral, I find that the M must have known that on occasions this was happening. I cannot tell whether she knew on all occasions.

292. My conclusion is that on the occasions she was present, she either gave the overdoses herself or was aware that the F was doing so. I do not think she was intending to harm Lucy, rather she thought this was what Lucy needed and she thought she was in a better position to make that judgement than were the hospital staff, who she believed to be incompetent, if not worse.

293. In the light of all the evidence, and the parents' lies on a number of issues, it is not possible to define more closely the responsibility and knowledge of each individual episode.